

“WHO ME?”

Who Commits Insurance Fraud and Why



Coalition Against
Insurance Fraud





Table of Contents

03	Foreword
05	The Coalition's Partner for the "Who Me?" Study
06	Introduction
09	Study Methodology
12	The Study Results
49	Conclusion
51	Appendix

FOREWARD

Since its founding the Coalition Against Insurance Fraud has been known as the only organization providing in-depth quantitative research addressing all aspects of insurance fraud. The Coalition tackles difficult issues spanning from our studies on the “Ethical Use of Data to Fight Insurance Fraud”, the “Globalization of Insurance Fraud” and “The Economic Impact of Insurance Fraud on the American Economy” which registers a staggering \$308.6B every year.



This year the Coalition celebrates our 30th anniversary. Looking back over the Coalition's many successes, it's hard to fully comprehend the challenges faced and the visions set by our founders and leaders three decades ago.

Never shying away from the challenge of its mission, the Coalition in 1997 at the young age of 4 years, first took on the daunting task of seeking to understand and report on consumers' psychological view of insurance fraud, its criminality and its impact on their lives. “Four Faces of Fraud” became a recurring study done every 10 years by the Coalition. The last being done in 2014 and the next slated for 2024. Over those decades we have been able to define and track America's changing views of insurance fraud. But something was lacking.

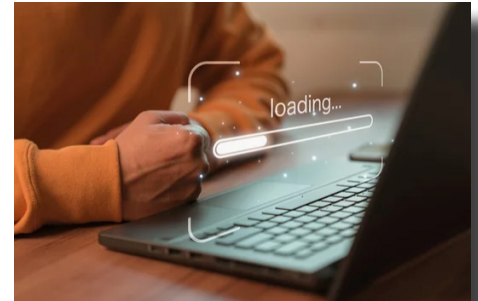
That something was depth. While our nation and world are constantly changing and evolving, in many ways we have never seen the dramatic differences occurring in our nation today versus when the Coalition was formed in 1993. Most historical accounts place the “birth” of the internet only 3 years before that of the Coalition. Not unlike every other aspect our lives, the internet has shaped how we conduct ourselves, including providing new avenues to commit fraud, and our views and opinions toward issues. These changes become amplified as we start to analyze the views of older versus younger generations. Not perhaps because their morals or ethics are that vastly different, but perhaps because their lives and views have been shaped by new events and technologies which they embrace fully having not known, or experienced, what occurred before.



For example, probably most Baby Boomer Americans did not routinely walk into their local record or CD store and steal a 45, album or disc of music. However, Americans today of all ages routinely unlawfully download and listen to copyrighted music without paying royalty fees. The idea? If I can get it for free off the internet, I am not stealing anything. Some may claim a lack of knowledge of copyright laws, but it's hard for

those same persons to claim ignorance of what they are doing by using the passwords of family members and friends to watch movie streaming services without having to pay the monthly fees. We too may be ignorant if we fail to pause and consider the impact of these cultural changes on the acceptance of committing insurance fraud and the willingness to participate in the financial gain it may bring.

It was for these, and many more, reasons a request was made to the Coalition's Research Committee during the pandemic to consider addressing more fully the psychological factors which are at play today and are driving the record amount of more than \$308B every year in insurance fraud. Insurance fraud is not only the crime we all pay for, but as this study sadly reveals, it may be also be the crime we are willing to accept, especially if we feel we may be able to benefit by committing fraud and not being caught. But you will have to read this study to understand the full impact of those statements and the depth of the knowledge and insight into the world of insurance fraud this study presents. Nothing of this magnitude has been undertaken, conducted or presented before on this crucial subject. Read on. You will not be disappointed and you will be enthralled as we were when these study results were revealed.



Before proceeding though, specific recognition is owed to those whose vision created this project, whose support made it possible and whose unparalleled skills and talents made it possible.

- No study by the Coalition is undertaken without the approval and oversight of our Research Committee. It was their direction and vision which set this project in motion and throughout the process their insight and guidance remain invaluable in every step of the process of creating, executing and reporting the results of this endeavor.



- When the idea for this study was first conceived the Coalition knew a powerful strategic partner would be needed to both financially support our research and to analyze the massive quantity of data we hoped, and ultimately far exceeded in receiving. While the Coalition is blessed with many incredible Associate Members who support our research and other work in many ways, for this study one member stood out and when we approached them the response was immediate, positive and never wavering. To our partners at Verisk© we appreciate all you have done to bring this study to fruition.

• Finally, but massively important to this study, is the incredible commitment and work of Dr. Kelly Richmond Pope. This is the first, but hopefully not the last, collaboration between Kelly and the Coalition. Her incredible educational background, intellectual insights and hours of interviewing the convicted insurance fraudsters whose stories are detailed in this study, drive in so many ways the powerful insights into how American consumers, and those who have committed insurance fraud and paid the price criminally, view insurance fraud and how insurance fraud fighters may be better equipped to fight fraud based on this study.



As always, the Coalition values your insights, opinions and recommendations regarding this and all of our studies. Thankfully, you continue to support these efforts as we carry out the work we perform for you as valued members. In the pages which follow we invite you to delve into the minds of your friends, neighbors, family members, and yes, even criminals, to gain a greater insight into how our nation views insurance fraud. In the end, if we have a better understanding of the psychology between insurance fraud, we will be far better equipped to address the fight and the challenges which are ahead.

VERISK – AN INDUSTRY LEADER AND COALITION RESEARCH PARTNER



Verisk, a leading data analytics provider for the insurance industry, is pleased to present the results of the Coalition Against Insurance Fraud study on the demographics and psychology of insurance fraud. This study provides valuable insights into the beliefs and

behaviors of American consumers regarding insurance fraud, which is a critical issue for insurers to address to protect their bottom line and the integrity of the insurance system.

As insurance fraud becomes more sophisticated, so must the tools used to fight it. Our advanced technologies, such as image forensics, artificial intelligence (AI), and machine learning (ML), allow us to detect and prevent fraudulent activity more accurately and quickly. By analyzing vast amounts of data from multiple sources, we can identify patterns and anomalies that may indicate fraudulent behavior, helping insurers to act before claims are paid out.

However, combating insurance fraud requires understanding the psychological factors that drive consumers to engage in fraudulent activity. The Coalition Against Insurance Fraud's study provides important insights into these factors, such as the perceived likelihood of being caught and the perceived severity of the consequences of committing insurance fraud. By understanding these factors, we can develop more targeted strategies for preventing and detecting fraudulent activity.

One of the most concerning trends revealed by the study is the increasing acceptance of insurance fraud among younger generations. The study found that Americans aged 45 and younger appear far more accepting of insurance fraud, even to the point of a significant number feeling envious of those who commit insurance fraud, inspiring them to want to do so as well. (Even older Americans appear to be far more accepting of at least some level of insurance fraud, than should ever occur.) This is a significant issue for the insurance industry as younger generations represent a growing segment of the market and will play an increasingly important role in the future of the industry.

Verisk is proud to collaborate with the Coalition Against Insurance Fraud in the production of this report. As a longtime partner of the Coalition, Verisk celebrates the Coalition Against Insurance Fraud's 30th anniversary of bringing together consumer groups, insurers, government agencies, legislators, prosecutors, academics, and other committed partners to fight insurance fraud. Together, we are committed to investing in cutting-edge technologies and research to help insurers stay ahead of the curve in the fight against insurance fraud. As partners, we will continue work to protect the interests of insurers and consumers and ensure the integrity of the insurance system for generations to come.

INTRODUCTION



America is a divided nation. At least here, that is not a political statement. Above any other piece of individual or collective data in this study, we learned a clear line of demarcation exists in our nation between older and younger Americans in how they perceive insurance fraud. Where the dividing line falls though may surprise you, and if you're a fraud fighter it should concern you.

Americans ages 45 and younger appear far more accepting of insurance fraud even to the point of a significant number feeling envious of those who commit insurance fraud inspiring them to want to do so as well. This is not an issue solely with "20-somethings", nor as Dr. Pope notes in her studies, is a "phase" these American consumers and policyholders will outgrow. A recent study by The Brookings Institute found persons under 40 now account for 50.7% of our nation's population. Those persons represent more than 166 million Americans. Importantly for understanding this study, this age, and those even younger, will continue thinking the same way for decades to come. In contrast the 162 million persons, mostly consisting of the "Baby Boomer" generation will increasingly dwindle

throughout the coming decades.



Make no mistake, even older Americans appear to be far more accepting of at least some level of insurance fraud, than should ever occur. Throughout this study though it is important to note “the spread” which represents the percentage gap between the responses of those consumers above and below the age of 45 years. For example, when asked the most basic question of “Do you consider insurance fraud a crime?”, older respondents said “yes” in a range of 87-96% with responses going higher as ages increased. In contrast, those under 45 answered the same question far differently. In that age group the highest number registered finding such actions criminal was 75% and it then skewed downward by age to only 64% who felt insurance fraud was a crime. To put that differential into perspective, there is a 32% spread between older and younger Americans in their lack or acceptance of insurance crimes. That equates to an astounding one-third shift of opinions of American consumer attitudes toward insurance fraud. Even more compelling is the fact approximately 30% of those under 45 (the midpoint of the range between 75% and 64%) not viewing insurance fraud as a crime equates to 50 million Americans feeling insurance fraud is acceptable. Imagine for a moment how this same statistic may well look in 15-20 years as an increasing number of older Americans pass away.



What is driving this vast difference between how older and younger Americans view insurance fraud? That is a far harder question to address, but this study does provide powerful insights to aid fraud fighters in making such assessments. Several years ago, the Pew Memorial Trust released a report finding younger Americans to have “emerged into adulthood with low levels of social trust.” Pew noted, “The future of an ethical society is looking grim and we can expect even more fraud in the

future.” Technology no doubt plays some role, but so do other factors. The recent book *The Man Who Broke Capitalism* cited a study by McKinsey finding 61% of current American CEOs would be willing to violate federal and state laws if necessary to meet quarterly financial reporting expectations of Wall Street investors.

While most insurers act honestly and ethically, reports of those who fail to do so resonate with consumers and often create the perception insurers place financial gain over policyholder interests.



Some insurance advertising blatantly drives the same messaging. This study was also conducted as our nation, and the world, continue to try to move beyond the COVID-19 pandemic. While those knowledgeable in the area of insurance policy coverage may be aware of “pandemic exclusions” most Americans are not. All they know is during a crisis, insurance carriers failed to provide coverage to many struggling small businesses which had paid premiums for many years. To ignore these, and other similar factors, in trying to ascertain how Americans view insurance fraud would be remiss and a mistake.



We urge you to read this study in depth and to spend even more time analyzing the graphs, tables and data contained in the appendix. Read as well the analysis by Dr. Kelly Richmond Pope as she takes you inside the minds of fraudsters and the crimes they committed.

Like any Coalition study we view this report not as an end but a beginning. Use the data and insights presented here to gain deeper knowledge and understandings of the world of insurance fraud. Put this same information to work to better develop plans and programs to fight insurance fraud. This is true whether you work with an insurer, a state or federal agency, regulatory authority or law enforcement agency,



provide anti-fraud services or resources or serve as legal counsel on anti-fraud matters. While a study such as this is always timely, this study comes at a crucial juncture. For the past several years insurers are increasingly cutting, outsourcing and paring down their anti-fraud efforts. The information in this study, especially “the spread” between attitudes and acceptance of fraud by those under age 45, should be a warning call that such actions, if they continue, may cause great peril and harm in the ability to effectively fight insurance fraud in the decades ahead.

STUDY METHODOLOGY



Unlike most of our studies, our analysis of the psychology of insurance fraud was done on two tiers. The first, sought to identify and analyze how American consumers view insurance fraud and insurance crimes. The second, delved deeper using the educational skills and talents of Dr. Kelly Richmond Pope to conduct in-depth interviews with convicted insurance fraud criminals to gain insight into their motivations, thought processes and even their justifications for stealing from insurers.

For our tier one consumer analysis, the Coalition again partnered with the worldwide research firm Dynata® to ensure our study met exacting standards. During February and March of 2023, Dynata ran the study across the United States until more than 1,500 responses were secured to match the same demographic standards as identified by the 2020 U.S. Census. Doing so allows the Coalition to confidently state these results truly do exemplify the insurance fraud views of all American citizens. Our study consisted of a total of 29 questions. Many contained multiple response choices and subparts. Some of the questions were double-tested to help verify respondents fully understood both the question and were affirming their views as consistent. Such questioning allows for a research study to have more credibility for reliable study analysis.

An initial screening question was added to verify the individual responding was responsible for the actual purchasing of an insurance policy for themselves or their household. Those responding who did not meet that criteria were not permitted to proceed with the study. Responses to the insurance fraud questions were mandatory for all study participants. While voluntary, at the end of the fraud-specific survey, respondents were asked to provide more in-depth personal identification information such as educational background, age, sexual and ethnic identifiers, their area of residence and even type of residential life from urban to rural. We appreciate greatly that virtually all study participants provided us their information freely. Doing so, allows for the further breakdown of the data, especially for future study, to determine how socioeconomic, geographic, political and even type of lifestyle characteristics may impact the views toward insurance fraud.



Once the data was collected by Dynata, it was then transferred to the Coalition. Our research partner, Verisk, committed an incredible team of data science analysts who then reviewed, analyzed and pattern-tracked each of the responses. Their work resulted in an Excel-based research dashboard. While impossible to verify, this may well be one of the richest data mines ever created of insurance fraud analysis. This dashboard allows the study data to be reviewed by question and then be “data sliced” in literally thousands of ways. If you want to know how college educated women, making more than \$100K a year, living in urban areas in the Pacific Northwest view workers compensation fraud, we can provide that data. The drawback is when sliced too thin, even with more than 1,500 responses the data pool is far too small. This is why the Coalition again stresses our research studies should never be an end, but a beginning. In the future the Coalition may re-run this same study to measure and track how respondents’ views change. Doing so, even once, in the same format would double the dashboard data pool. Equally though, the Coalition has never “locked down” its research either. Meaning, if other credible research is done on this same important subject matter, it may well be possible to aggregate the data together.

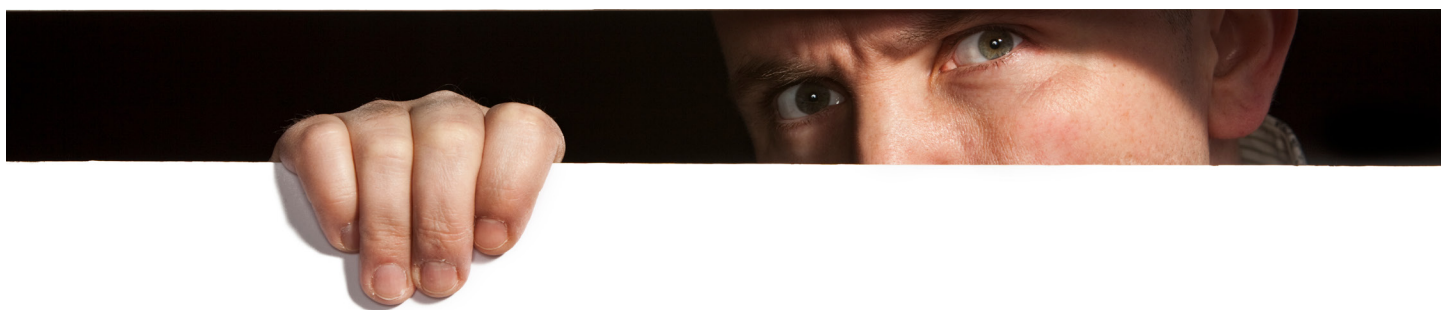


Over years, or decades, the potential to create a live, interactive dashboard of how Americans view insurance fraud, would be an incredible step forward in the fight against insurance fraud. The foundation to do so, is now a reality and is the foundation of this study.

Tier two of the study rests on the incredible life work and skills of our partner, Dr. Kelly Richmond Pope. Please take the time to read Kelly’s full biography which is contained in the index. Kelly is a renowned author, education innovator and forensic accounting expert focusing her career and studies on the world of insurance fraud. She is the author of Fool Me Once her new book on scams

and stories in the world of insurance fraud investigations. Dr. Pope is a professor in the School of Accountancy and MIS at DePaul University in Chicago where she teaches forensic accounting, managerial accounting, financial accounting and ethical leadership. She is also an avid film producer using that media to portray the stories of the many fraudsters she has investigated in her career.

For the second tier of this study, Kelly conducted personal interviews with five criminally convicted insurance fraudsters. Their insurance crimes ranged from car rental coverage to a phony addiction center, spanning 5 states. Losses associated with the insurance crimes they committed ranged from \$33K to \$950M. Final decisions on which cases to accept for the in-depth tier two interviews, were made jointly by the Coalition, Dr. Pope and our partner, Verisk. We sought to identify cases representing differing geographic areas, targeting diverse lines of insurance business and ranging in the monetary exposure or loss the crime inflicted on its victims.



In each interview, Kelly sought to gain insight into the fraudster's thought process at each step of the insurance crime process. From identifying the type of crime to commit, to selecting the targeted company, to how the crime was constructed and executed. She also explores how the criminal potentially justified their actions as being either "not that bad" or even somehow "beneficial" to create a more level and equitable insurance claim recovery. She also goes into the thoughts at the moment the fraudster realized their crime would not succeed and they were going to be held accountable.



Quite simply no other researcher in America possesses or could bring to this study the specific knowledge, education and skill sets of Dr. Kelly Richmond Pope. In one final testament to the quality of this study, and to the quality of Dr. Pope herself, when contacted and asked to be a part of this groundbreaking research project, Kelly agreed to do so immediately and without hesitation. Even more striking, when it came time to ask the question of her fee for services, Dr. Pope's response to the Coalition was telling, "I want no fee payment. Being a part of this study is part of my way of giving something back to the anti-fraud community and their work." Thank you, Dr. Pope for your help and support in so many ways.

THE STUDY RESULTS – TIER ONE CONSUMER ATTITUDES TOWARD INSURANCE FRAUD



Where do you begin in trying to statistically map and analyze the most complex of all creations, the human brain? Especially when you are seeking to gain insight into not only each mind's specific view of the insurance fraud crimes, but also gain insight into why they hold those beliefs and how those feelings and opinions – be they right or wrong – were shaped and developed. If the saying the “tip of the iceberg” applies to most circumstances, for purposes of this study the summary provided here is the “drop of water at the tip of iceberg.”



Here we will present the briefest of highlights of the vast data available in this study. This section is solely intended to provide a very top-level analysis of key data points.

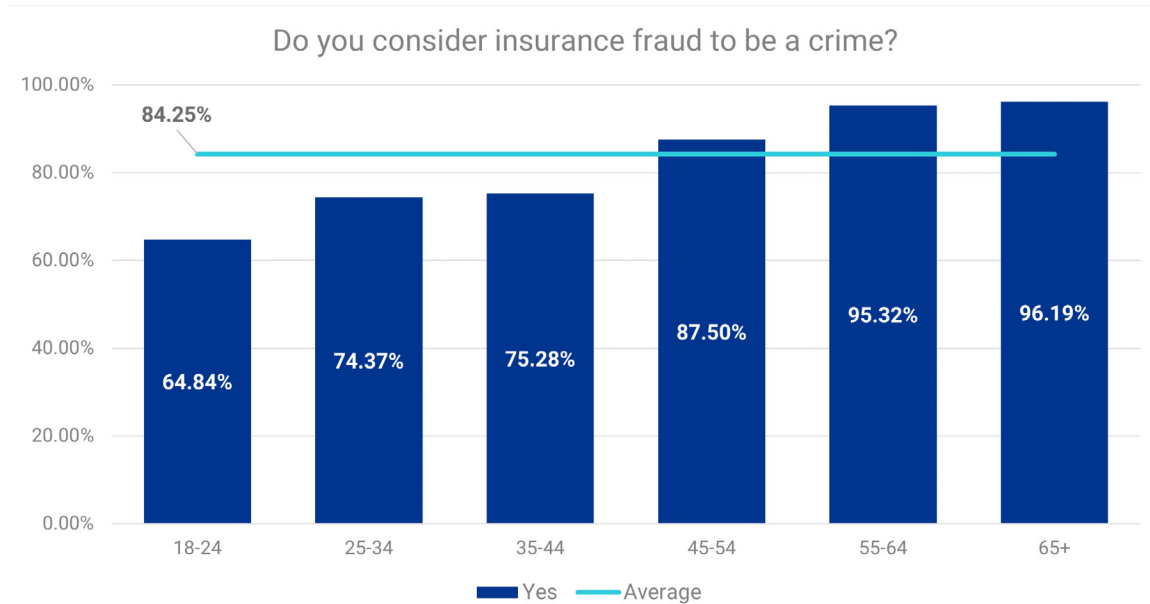
To truly understand, apply and seek ways to improve and change anti-fraud efforts, we strongly urge you to not pass over, but delve deeply into the study results set forth in the appendix. It is there you will truly begin to see and comprehend what we can only briefly summarize here.

DO AMERICANS VIEW INSURANCE FRAUD AS A CRIME?



This question is key to our study. It was not, however, placed at the front of the study questions. Instead, it appeared toward the end. The rationale was to make certain we did not gain a simple immediate response, but instead we sought the views of consumers after they had already

participated in the study and were hopefully thinking a bit deeper about the impact of insurance fraud crimes on society overall and them personally.



With those thoughts in mind, it is marginally reassuring to note 84% of all Americans do consider insurance fraud to be a crime. Before, however, we celebrate too much, a deeper analysis should be considered.

With a current population of 332 million in the U.S., even this high of a percentage still means 16%, or more than 53,000,000 of our nation's citizens are unwilling to accept that stealing from an insurance company is wrong or criminal. This concern is magnified when you consider the screening question to participate in the study required all respondents to be the person responsible for purchasing insurance policies for themselves or their household.

But why? We not only wanted responses to our questions, but to try to understand what drives those persons who hold this view to believe the way they do. The results may not be all that surprising, but are no less important. Almost 9% of all respondents justified insurance fraud as not being wrong or criminal based on their belief "insurance companies rip people off, so it's fair." This category led all other responses. When combined, however, with the justification statement "I pay them enough, it's my money I'm getting back" at 3.2% the combined response rate rises to 12.03% or nearly 40 million



persons. The final category represents the hardcore belief that under no circumstances is stealing insurance money wrong or improper. "No, not at all" was actually the second highest response rate at 3.72%.

As previously noted, and depicted on the chart above, a significant shift of attitudes toward this most basic of questions occurs just around age 45. Nearly all Americans over age 55 view insurance fraud as a crime. As will be addressed later, that alone does not mean they are unwilling to accept or even participate in such actions, it simply means they understand doing so is both wrong and criminal. But between the age brackets of 45-54 and 35-44 we see a major drop of 12.2% in recognizing insurance fraud as crime. It should be noted as well, even for those over aged 45-54 there is an almost equal drop of 12.3% compared to persons aged 55-64. Combined, these figures alone demonstrate a drop of 24.5% in viewing insurance fraud as a crime for persons under the age of 64 years.



That alarming trend continues in respondents of younger ages. For those respondents under the age of 24 years, and who are insurance purchases, a shocking 35.2% do not believe committing insurance fraud should be viewed as a crime. What should be of

perhaps greater concern is why they feel this way. In that age category nearly 20% justified insurance fraud because they believe “insurance companies rip people off, so it’s fair.” Simply passing off such beliefs is not wise as most psychologists and psychiatrists generally agree our basic moral, ethical and societal beliefs are developed by our late teens or early twenties. This youngest group of respondents will also be the longest in place policyholders. They will also be the ones submitting insurance claims for decades to come. And most importantly, their views of how insurers act, and accordingly why it is appropriate to steal back from those companies, will be the same thoughts they will instill into their children impacting future generations of consumers to come.

WOULD YOU COMMIT INSURANCE FRAUD?



While disconcerting, it is one thing to believe insurance fraud may not be a crime. What is more disconcerting is a willingness to then act upon those feelings and knowingly participate in committing insurance fraud. A surprising number of Americans though appear to be ready and willing to do so.

To gain insight into this topic we presented respondents with a series of acts which, in virtually any U.S. jurisdiction, would be an insurance crime. These actions included inflation of otherwise legitimate losses to submitting of blatantly fraudulent claims for property never owned or injuries which never occurred. Each of the subparts to this question setting forth the fraud scenario is detailed in the appendix. For this analysis we have selected three of the subcategory responses as reflective of the overall responses.

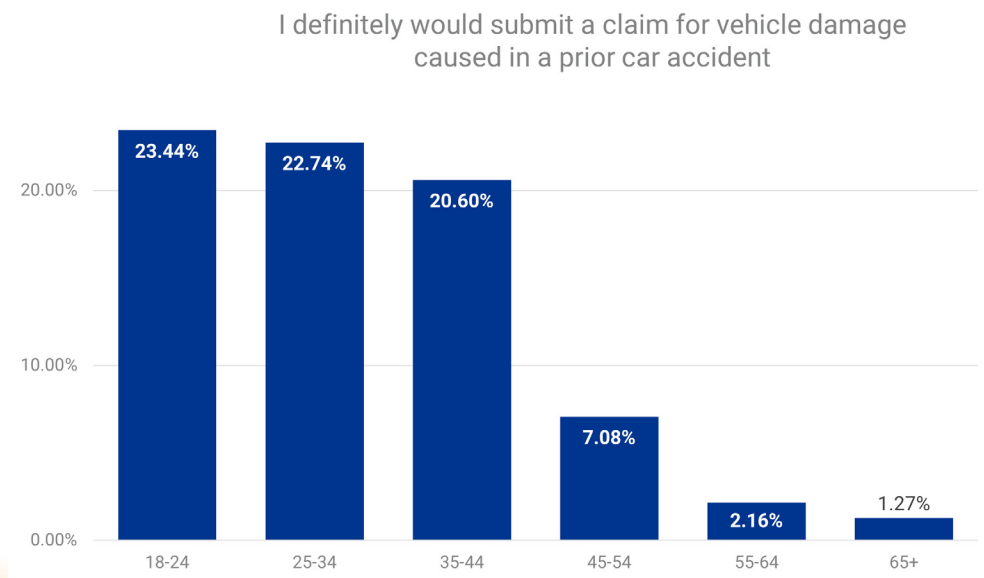


A. Submitting a claim for pre-existing vehicle damage following an accident.

We all know it occurs, but how often? And, are such actions viewed as improper or perfectly acceptable? The responses we received may surprise you, both overall and when analyzed by age group.

At the macro level, a somewhat surprising 5.71% of all respondents to the study informed us what they had actually done on a claim which they personally submitted for payment. But wait, it appears they are just waiting for their chance to commit a similar fraud. Beginning at the baseline of those who admitted to committing such acts is the even more shocking 11.63% of all persons responding telling us given the opportunity to submit such a fraudulent claim they would “definitely do so.” Combined this represents 17.34% of all respondents. But the lack of a moral high ground does not stop there. Rather than finding such actions to be unacceptable, the next group of 17.34% (34 matching exactly the same number as the two prior respondent groups) just of all respondents simply said “I might” when asked about submitting such a claim. Collectively then these responses represent the views of 34.68% of all U.S. citizens. Converted to direct population this represents how more than 116 million consumers in our nation are tolerant or willing to submit fraudulently inflated auto damage claims.

The statistics though become more compelling when analyzed by age. Especially as more insurers race to adjust and pass auto damage claims especially on a “pass through” basis with little to no human touch, and often with only minimal at best, anti-fraud efforts being considered. Insurers would be wise to consider what the future will hold given these responses.



In the above chart we analyze only the issue of whether a person definitely would submit a damage claim following an accident for damage they knew existed on the vehicle before the accident occurred. For those over the age of 65, only a statistically minimal 1.27% would engage in such behavior. On the other end, however, of the age spectrum we find 23.4% of the youngest respondents (18-24 years) would absolutely do so without hesitation. The clear line of demarcation though falls two decades before the top age of the youngest group. For Americans aged 44 years and younger there is a striking difference in their blatant willingness to submit claims for what should be excluded damages. Something in our nation or society changed. The chart above dramatically illustrates the startling higher acceptance of fraud between two age groups: 45-54 years old at 7.08% and 35-44 years old at 20.6%. From there the acceptance of fraud continues to rise.

Will insurers choose to investigate these inflated claims by committing human or automated anti-fraud detection efforts? Time will tell. But even the best image alteration software may not detect pre-existing damage on a vehicle absent locating a prior image uploaded on the internet. At the current time it appears insurers are more willing to simply let such claims “pass through” with payment, recapturing the loss through higher premiums. These statistics, however, may call into question the wisdom of doing so in future years.

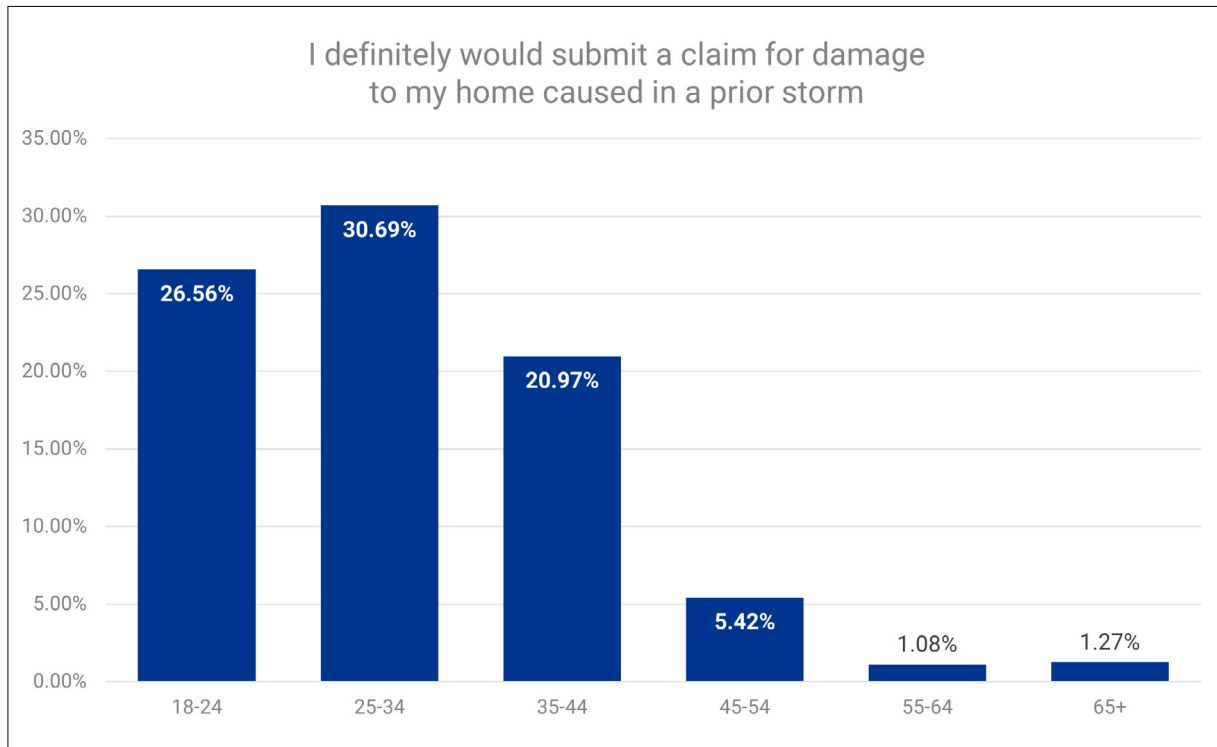
B. INCLUDING DAMAGES WHICH OCCURRED BEFORE A STORM IN A PROPERTY LOSS CLAIM.



A bumper with prior damage on a car involved in a subsequent rear-end collision may be one thing, but what do consumers feel about intentionally claiming pre-existing home damage on an otherwise legitimate loss claim? This would appear to be an even more intentional action, and potentially involve far more in the monetary inflation of the claim. Yet, the acceptance and willingness to commit this form of insurance fraud is actually even higher than on auto damage claims.

Across the board the percentage rates of persons admitting to having inflated a property damage claim by including pre-existing damage (5.25%), who definitely would do so given the opportunity (12.96%) and who might do so (18.01%) all increased. Combined, this equates to 36.31% of all Americans seem to find property fraud acceptable. By population numbers this equates to more than 120,000,000 Americans who told us they have, definitely will or well might commit insurance fraud on a property claim. As natural disasters seem to both be increasing and becoming more severe, the

monetary fraud losses attributable to this type of accepted fraud could easily be in the tens of billions of dollars each year alone.



At the start of this report, we drew your attention to how the “spread” of American attitudes toward insurance fraud changes at approximately age 45. The above chart illustrates this phenomenon dramatically. When asked if they “definitely would” intentionally inflate a property damage claim to have pre-existing damage repaired, the combined responses of all persons over age 45 ranged from a “high” of only 5.42% to a quite admirably low of only 1.27% of consumers over 65 agreeing they would do so. The responses of those 44 and younger tells a dramatically different story. Over 30% of 25-34 years old respondents affirmed they would definitely commit this form of insurance fraud. Their percentage of willingness to do so exceeded both those younger than them (26.56%) or slightly older (20.97%). Regardless, there is a clear difference, and danger, in the willingness and acceptance of American consumers under the age of 45 to willingly participate in property insurance fraud to improve their homes by correcting damage which existed before their legitimate loss occurred.

C. SUBMITTING A PERSONAL TIME RECREATION INJURY AS BEING AN ON-THE-JOB WORKERS COMPENSATION INJURY

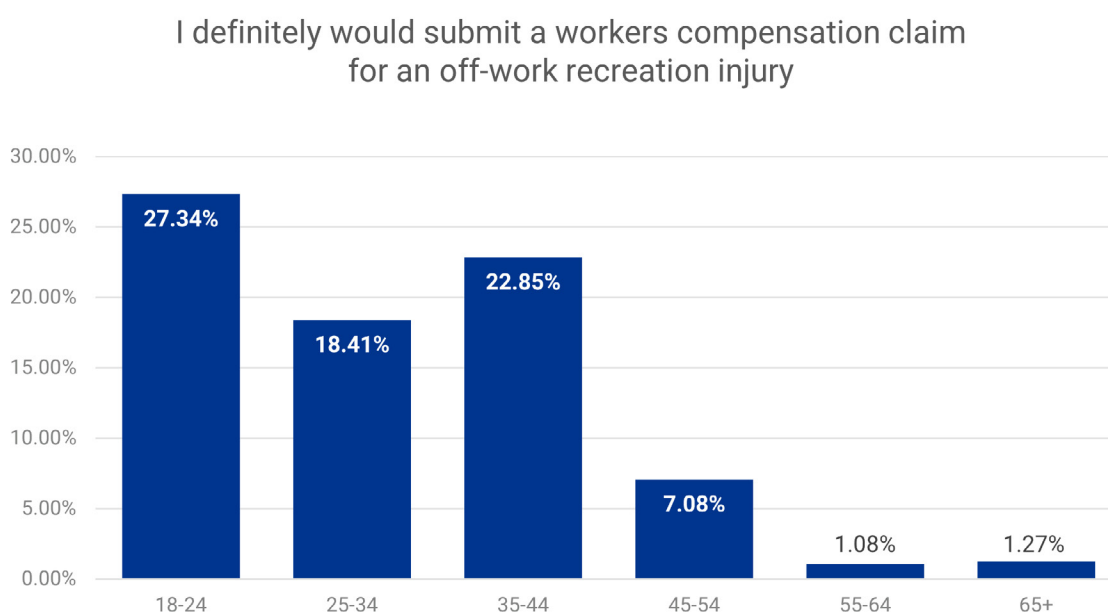


Completing the “insurance fraud trifecta” we also looked at attitudes toward submitting a fraudulent workers compensation injury claim. Whether for a car, real estate or the human body, the acceptance of stealing on an insurance claim appears to remain fairly constant.

Drawing from the combined overall responses, 5.71% of persons admitted to have already submitted a non-job injury to their employer to be paid. Based on the Coalition’s study in [2022 on Workers Compensation Fraud](#) this alone could constitute nearly \$1.5 billion each year of fraudulent workers compensation claim payments.

Others have not yet had the chance. Persons who say they “definitely would” submit such fake injury claims accounted for 11.36% of responses, even exceeding those who told us they “might” consider making such a claim at 10.50%. Collectively these groups accounted for 27.57% of all respondents, yet again representing a very high acceptance rate for the commission of insurance fraud in our nation across multiple lines of insurance, and even when doing so would involve not only lying to the insurance carrier, but also to your employer.

Again though the “spread” helps us to better understand these responses and gain insight into the what, if left unchecked, the future will hold.



Over age 55 only slightly more than 1% of respondents say they would definitely commit such fraud. Unlike most other responses we did see a slight uptick of persons 65 plus being willing to submit non-work injuries for comp coverage at 1.27% compared to their slightly younger counterparts at 1.08%. A factor potentially driven by increased medical costs, but over all a negligible differential. As with other responses we begin to see a slight increase to 7.08% would submit these types of fraudulent claims in the 45-54 years age bracket.



What is not negligible, nor ignorable are the responses of those aged 44 years and younger. More than a quarter (27.34%) of the youngest age group would have their sports or home injuries paid for by comp insurance.

There is a slight dip down to 18.41% in the age 25-34 group before rising again to 22.85% of 35-44 years old respondents.

With the U.S. Census Bureau reporting 10,000 Americans will turn age 65 every day from now until 2050, many of the apparently most honest, or at least anti-fraud, workers of today will be retiring in the coming years. While some of these persons may still have their chance to commit workers compensation fraud, underwriters and employers who pay premiums alike should heed the chart above as they consider the risks associated with fraudulent non actual work injuries being reported as compensable in the decades ahead.

D. SUBMITTING MEDICAL BILLING FOR TREATMENT NOT RENDERED.



Committing insurance fraud individually is one thing, lying to involve your employer is another, but intentionally colluding with someone else to commit insurance fraud escalates the scale to a far greater height. But apparently when it comes to fraudulent medical billing a fair number of Americans are willing to partner with their doctors, clinics and therapists to do that exactly. And not just to up-charge for

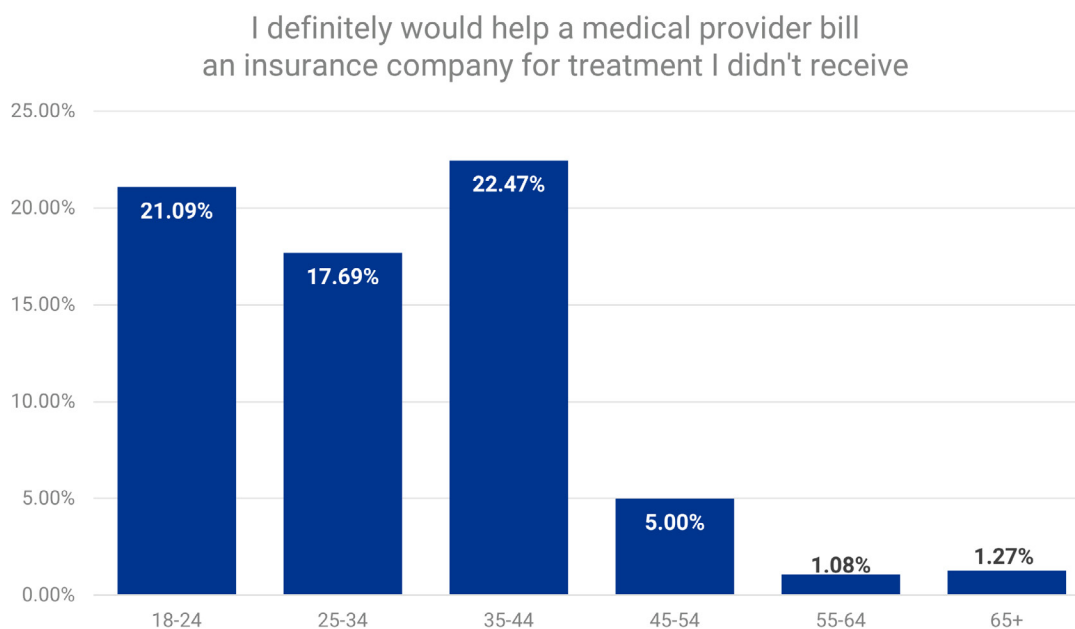
treatments, but to intentionally help medical providers bill insurers for treatments and services their patients never received.

The study question was very clear asking respondents if they would help a medical provider bill an insurance company (not the federal government) for treatment they never actually received. To respond at any level other than saying “never” requires a direct admission of being willing to commit and collude to steal from an insurance care in a very blatant way. Yet, more than a quarter of all respondents indicated their willingness to do exactly that.

Some already have with 5.12% of all respondents admitting they had already done so with a medical provider. According to the National Association of Insurance Commissioners, health insurers alone

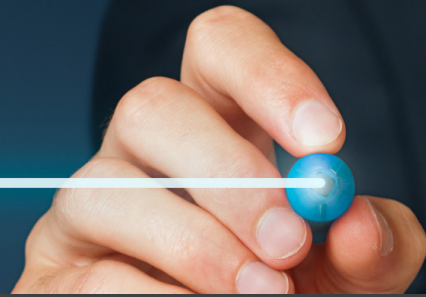
pay out \$674.4 Billion every year for hospital and medical expense claims. Those figures do not include what is paid by auto, property and workers compensation carriers on an annual basis as well. While there may well not be any direct correlation, for illustration purposes only, if the same 5.12% of those payments are fraudulent (and estimates by the Coalition and others places the percentage of medical insurance fraud far higher) then we are already facing a fraud loss of \$34.5 Billion every year.

On top though of those who have already knowingly colluded to commit this form of insurance fraud, our study also showed 10.30% of respondents would “definitively” help their medical provider steal from the insurance carrier and another 10.23% said they may well do so given the opportunity. Collectively then these responses equate to 25.65% of the total respondents across all age groups.



While more than a quarter of all age group respondents is significant, yet again we see a dramatic divide based on the same age parameters. As before, only slightly more than 1% of the oldest two categories of respondents (aged 55 and above) say they definitely would commit this type of fraud. The response rate just about quadruples though when persons 45-54 years old are asked the same question. But that pales in comparison to the dramatic rise of the willingness of those under the age of 45 to collude with medical providers and submit fraudulent billing to insurers for treatments never rendered. As the above chart denotes, it is actually the older tier of those under age 45 who are most willing to do so (22.47%) with about a 5% drop occurring among those 25-34 years old before again rising to above 21% in the youngest category of 18-24 years. An interesting observation in the data is that when the question on this type of medical fraud goes from the standard of “I definitely would” to “I might” the statistical responses between 35-44 and 25-34 years old respondents almost exactly switch with those in the 25-34 year range being the higher age group which would consider committing this form of insurance fraud.

Summary



We knew this multi-part question of our study would contain a wealth of data point information and we were not disappointed. We selected only these few subparts of this multi-pronged question to provide you with a view of multiple lines of insurance from auto to medical, but also because each subpart arguably increases the level of fraud often monetarily but certainly in regard to being willing to knowingly and intentionally commit the fraudulent act either by yourself or in collusion with another.

There is no way to simply claim the persons whose views are reflected here were simply naive or became involved in insurance fraud they were unaware of occurring.



Some who read this section may instead point out we focus on the glass being “half empty” rather than “half full”. That statement is true given the fact for each question the majority of respondents, ranging from 63-74% said they would never consider committing such actions. However, insurance fraud is never going to be driven by the majority. The entire purpose of having a strong anti-fraud program and investigation effort in place is to target the far smaller percentage who engage in fraudulent insurance actions. For years, many insurance carriers, trade associations and governmental agencies have used an unverified statistic of perhaps 10% of all claims having an aspect of insurance fraud. The responses to this study question though are a strong challenge to that long-held but unproven belief.

First, across the board we generally see more than 5% of all respondents admitting they have already committed the fraudulent practice they were being asked about. That alone is a shocking baseline when it is considered any respondent to this study was admitting in a public study they were an insurance criminal to some degree.



Second, and more alarming though is the extremely high number of responses – especially from those under age 45 – of their willingness to commit such fraudulent actions given the opportunity to do so.

The apparently most honest of policyholders (ages 55 and above) in future decades will continue to be a decreasing percentage of our population and our collective anti-fraud conscience. In their place will be those respondents who appear quite eager to be willing participants in the commission of insurance crimes, even when it requires implicating their employers or colluding with their doctors. All of this is unfortunately occurring at a time when the vast majority of U.S. insurers are devoting far less staffing and financial resources to the fight against insurance fraud. In short, the “perfect storm” may wait ahead. The next sections further explain why.

HOW DOES KNOWING SOMEONE WHO COMMITTED INSURANCE FRAUD MAKE YOU FEEL?

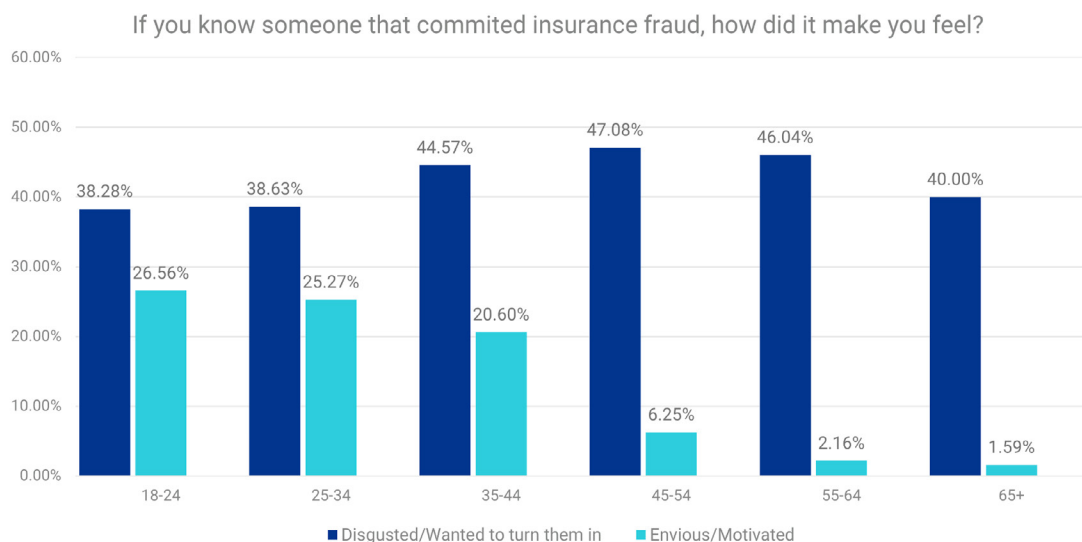
If we see a significant number of persons, especially younger respondents, assuredly stating they “definitely would” or “might” commit insurance fraud, the deeper question is what in their psyche would lead them to be willing to commit such acts and crimes?



Before addressing that question fully, however, it sadly appears most Americans are ignorant of the extent of insurance fraud or who commits such acts.

When we asked in the survey “If you know someone that committed insurance fraud, how did it make you feel?”, nearly half (45.05%) claimed to not know anyone who had committed insurance fraud. Apparently, most consumers fail to truly comprehend it is their friends, neighbors, co-workers and family members whose actions all drive the more than \$308.6 Billion of annual insurance fraud cost in our nation. Of course, this also means an equally surprising 54.95% of our nation’s population, a clear majority, are well aware of someone they know having committed insurance fraud.

Keeping in mind the importance of the “spread” between older and younger respondents is vitally important to also understand responses to this question. Many readers of the above section may be dismissive believing younger persons are just boasting of their willingness to participate in insurance fraud crimes, but when pressed they would not actually do so. Before jumping to that conclusion, consider their responses.



The highest percentage of respondents who do in fact know of someone committing insurance fraud is not the older age groups who would have had decades to observe and learn of such actions. Above age 45, those knowing someone who committed insurance fraud goes from 46.67% (45-54 years) to 58.41% (over age 65). Such responses tell us older persons are less acquainted with insurance fraudsters, perhaps because fewer of their contemporaries are willing to engage in such acts.

Yet again though the responses of those 44 years and younger. This is the group where clearly the highest number of respondents do in fact know someone who has committed insurance fraud. Proving statistically younger Americans are not only more overall accepting of insurance fraud, are participating in and committing it in far greater numbers than their older peers, or are least being more boastful when they do so.

In the below 44 age group respondents, every age category recorded more than one-third of the respondents saying they did not know someone who had committed insurance fraud. The statistical spread among those under 44 is negligible (ranging from 34.83% to 36.10%), however, the spread between the highest group not knowing insurance fraudsters (age 65+) and those who apparently know the most fraudsters (35-44 years) is 23.58% or nearly a full quarter of all responses.



But how do Americans, normally thought of as moral and ethical citizens, feel when they do know someone has committed “the crime we all pay for.” That too, may surprise you.

In this category fortunately the highest response level at 33.69% percent was “disgusted.” This was also one response category where age did not play a significant factor in responses ranging from the highest level of disgust being 45-54 years old (37.92%) to 29.69% among 18-24 years old.

What is telling though is respondents were also given the option of responding “they wanted to turn them in.” While response rates were low to being willing to do so, the age group least willing to report fraudsters is actually those over age 65 with only 4.76% saying they would be willing to do so. When it comes to reporting insurance fraud, the only age brackets logging in at more than 10% are 35-44 years old (12.36%) and 25-34 years old (10.11%). These statistics may show some promise for fraud investigators and law enforcement in the future. For example, targeting anti-fraud messaging to younger consumers about the financial impact of insurance fraud and the need to report such actions to avoid higher costs, may resonate with this generation. But as we will see, not with all.

While fraud-fighters would like all responses to be against insurance fraud crimes and espouse a willingness to turn in criminals, we also included options to see if knowing someone who committing insurance may spur even more persons being willing to commit such crimes. Sadly, the answer is yes.

Overall, respondents who told us knowing someone committed insurance fraud made them “envious” and “motivated to try it” registered more than 10% of all survey responses at a combined 12.19%. Stated statistically, if 54.95% of America’s 332 million citizens know someone who has committed insurance fraud, and that knowledge made them envious and willing to do the same, this equates to a mind-blowing potential of more than 18 million policyholders just waiting for their chance to jump on the insurance fraud payment bandwagon.

The age spread though once again factors in importantly in analyzing the propensity of persons to knowingly and willingly commit insurance fraud. In the youngest age group of 18-24 years old, more than a quarter of the persons in that group (26.56%) gave responses of “envious” and being “motivated” to commit insurance fraud. A statistic every insurance underwriter, claims handler, fraud investigator and insurance executive should note, along with regulators and law enforcement

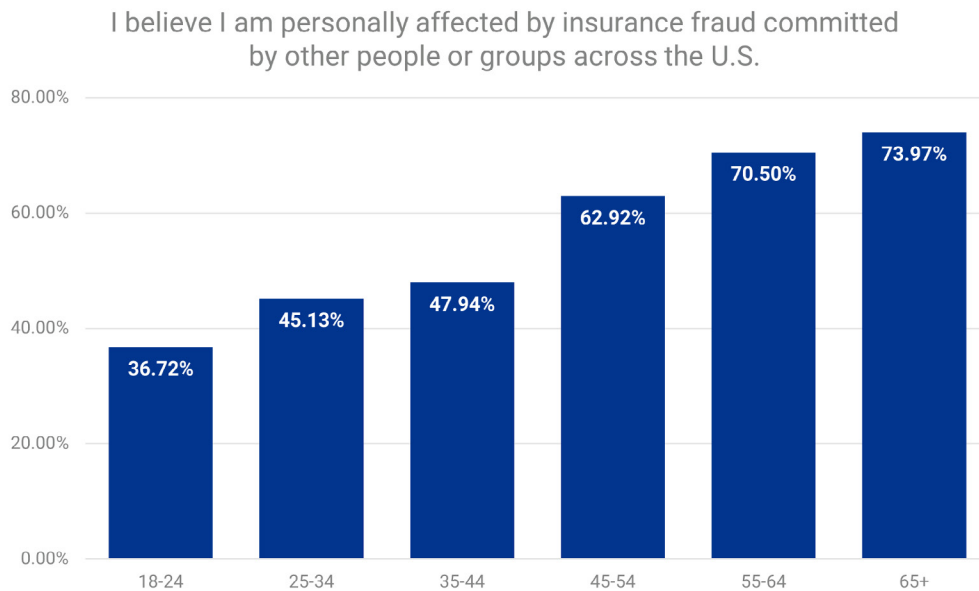
agencies. The next age group as well (25-34 years old) also tops-out over 25% coming in at 25.27% of respondents in that bracket. Moving up to 35-44 years old, still reveals a propensity to envy and commit such acts at an alarming 20.60% rate. It is not until you go to age brackets 45 and above that you begin to see the dramatic drop. In older demographics the acceptance rate for “envious” and “motivated” ranges from 6.25% (45-54 years) to a mere 1.59% for those over age 65. In this response alone we observe a 24.97% swing between the oldest age group and the youngest in the apparent acceptance of, and willingness to participate by committing, insurance fraud crimes. Analyzing responses here is far easier than accurately predicting what impact such feelings and motivations will have on driving insurance fraud in the decades ahead.

ARE YOU PERSONALLY AFFECTED BY INSURANCE FRAUD?

To really care about something, we have to feel how it affects and impacts our daily lives. To motivate Americans to address and help stop insurance fraud, they first must appreciate how it affects their lives and impacts them personally, especially financially. That is one of the key reasons the Coalition felt it was imperative to update the estimate of the financial impact of insurance fraud, showing it costs every living American citizen more than \$970 each year.

But are our fellow citizens receiving that message? Apparently, the answer is a qualified yes with 58.47% saying they do feel the impact of insurance fraud. Intriguing is the potential for educational and information campaigns to vastly increase that number. While “yes” was the overwhelming response, the next highest response rate was “I never thought about it” coming in at a very high 23.19% of all responses. If we can effectively message to and convince that uniformed group of the negative impact of insurance fraud, thereby converting them to “yeses,” the result would be 81.66% of Americans feeling directly affected and their lives impacted by insurance fraud. Numbers such as those are where the potential rests for truly making significant societal changes in behavior.

The remaining responses to this question skew to the negative with an overall 15.15% feeling they are not affected by insurance fraud (they too though could be educated) and 3.19% saying they “don’t care.”



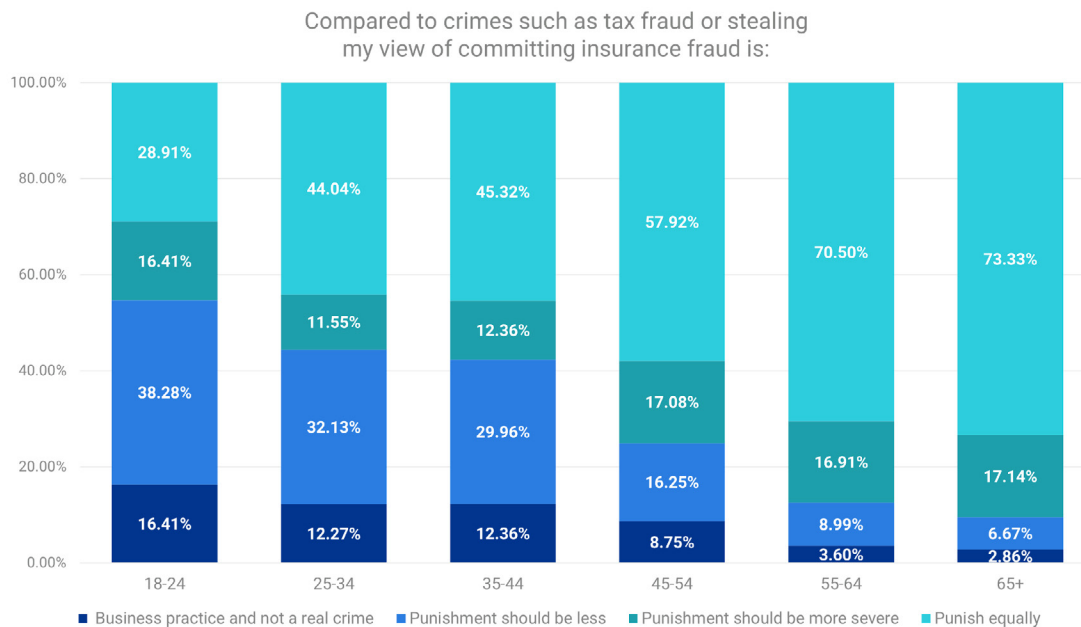
The need for consumer education and informational messaging on the harm of insurance fraud is well-demonstrated in the chart above. It is clear older Americans feel far more impacted by insurance fraud than their younger counterparts. A clear demarcation between response rates well above 50% and those falling below that rate is present at the age 45 breakpoint. Keeping in mind, the higher acceptance rate, levels of envy and motivation to commit insurance fraud all being present among this same younger age demographic, should be a siren warning call for insurers, consumer activists, regulators and legislators to provide the financial, creative and staffing resources to commit to a national effort to demonstrate how insurance fraud crimes impact and harm not only our economy but also every American citizen and family. Using effective outreach, information campaigns and successful legislative and judicial advocacy, allowed MADD to dramatically drop the number of drunk driving deaths in America by more than 60% in less than two decades. Insurance fraud leaders should look to follow the MADD “playbook” if we sincerely want to battle back against insurance crimes in the future.

HOW DOES INSURANCE FRAUD MEASURE UP COMPARED TO OTHER FINANCIAL CRIMES?

Many policyholders who would never consider walking into their local store and stealing an item by shoplifting, will nevertheless participate in insurance theft to garner monies for which they would not legitimately be entitled under their policy or claim. They do so, we generally believe, because they feel doing so is not on a par with other crimes such as theft or even tax evasion.

In the study we asked persons to rate insurance fraud compared to those other types of crime. Their responses are mixed at best. On an overall basis, 56.21% equate insurance fraud equally to stealing or tax evasion. However, a disconcerting high number of 28.63% of all respondents told us insurance fraud was “not a real crime” (8.5%) or constituted a “business practice with no real victim” (20.13%). In that group, insurance companies themselves, and not all consumers through higher premiums,

are viewed as the sole victims of insurance fraud crimes. 15.15% of respondents though did feel insurance fraud crimes warranted more severe punishment as a crime due to the impact of driving up insurance costs for everyone.



Age again plays an extremely significant role in these responses and how our fellow citizens view insurance fraud crimes. As the chart above the percentage of responses who equate insurance fraud crimes on an equal basis with stealing and tax fraud steadily declines as the age brackets move downward. More disturbing is the fact the percentage who fail to recognize insurance fraud as not a real crime and merely a “business practice” increases exponentially from 2.86% of respondents over age 65 to an almost 8-fold rise to 16.41% of those respondents between 18-24 years. The same holds true for those who believe insurance criminals should receive less punishment since there is “no real victim” and only an insurance company. Only 6.67% of older respondents agree with less severity of punishment for insurance fraud but that figure steadily raises by more than 6 times to 38.28%, or just under 40%, of respondents in the youngest age bracket. Combined, the youngest group of respondents register in with a truly shocking 54.69%, clearly more than half, saying insurance fraud is not a real crime, amounts to only a victimless business practice and should receive less punishment. This majority view does not bode well for deterring or criminally punishing insurance scammers in future years.

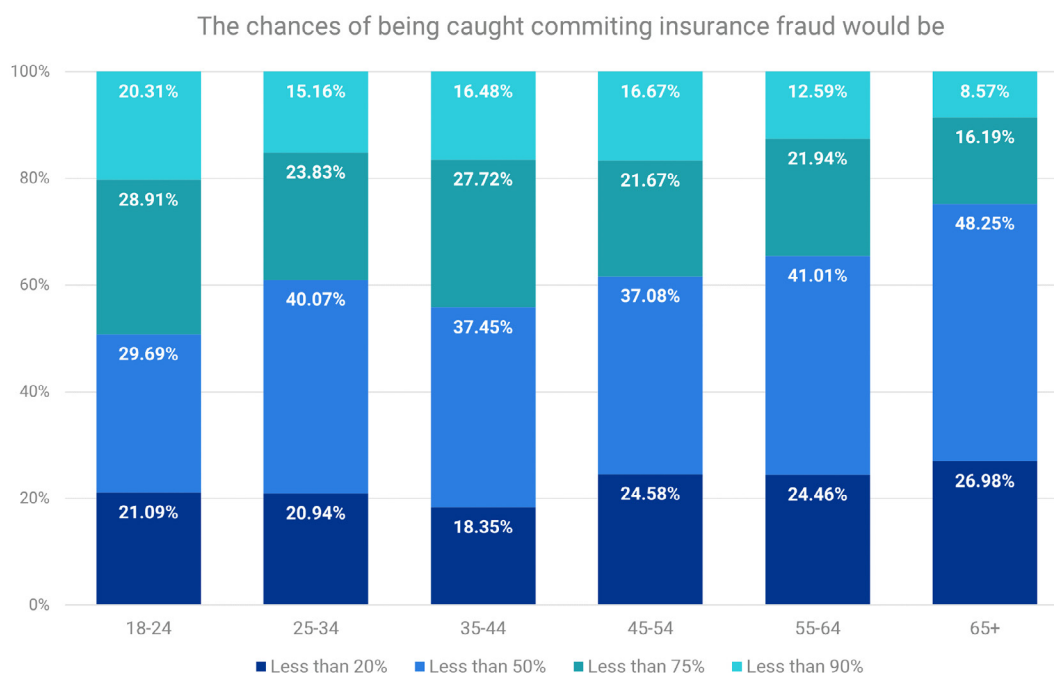
One relative constant response though across the age brackets is the relatively small number who not only realize insurance fraud is a crime, but feel those criminals should actually be punished more severely because of the impact of their crimes on innocent policyholder premiums. While older Americans agreed with that statement (17.14%), more respondents over the age of 45 consistently ranked this response at near or above 17%. In the younger age brackets below age 44, respondents from 25-44 favored harsher punishment in the range of 11.55 to 12.36%, but a noteworthy rise then

actually occurred in the youngest bracket with 16.41% of 18-24 years old respondents favoring stronger punishment. Their number almost matched identically the same response level of those 55-64 years at 16.91%. This yet again points the potential to “bend the curve” by providing more education and information on the harm of insurance fraud to younger Americans. An investment now could certainly pay dividends in anti-fraud returns over the remaining decades of their lives and how the standards and beliefs they in turn instill in their own children.

WHAT ARE MY CHANCES OF GETTING CAUGHT IF I COMMIT INSURANCE FRAUD?

A speed limit sign does little to actually stop speeding. What does is the chance a police official with radar may catch us and issue a costly ticket. In short, the risk of being caught is what deters us from acting. The same is true of insurance fraud. As we have seen from the psychological insights in preceding questions, persons have, definitely will or might commit insurance fraud in increasingly high numbers. If they have little fear of being caught doing so, or lack a fear of any real repercussions if they are caught, then there is little hope in stopping an insurance fraud juggernaut.

Most Americans feel they have a fairly decent chance of getting away with insurance crimes.



Across all demographics more than 60% of all respondents feel they stand a better than 50/50 chance of getting away with their insurance crime. Based on overall responses 63.1% of surveyed consumers felt they risked a 50% or less chance of being caught committing fraud. Raise the bar to less than 75% chance risk and the percentage rises to 85.69%. All told only 14.31% feel they have a very high risk of being caught if they partake in insurance fraud.

While the age spread here is not quite as significant as to other questions, it is nevertheless telling. As we have seen before older Americans (above 45 years old) mostly express more fear of being caught committing insurance fraud than their younger counterparts, but not always or by very much. Keeping in mind the very high percentage of younger persons expressing their near approval for, and willingness to commit insurance crimes, they apparently hold that belief even if they may get caught doing such acts. 61.01% of 35-34 years old respondents feel they risk a more than 50/50 chance of being caught. The younger age brackets surrounding them equally feel at 55.8% (35-44 years) and 50.78% (18-24 years) they may well be caught if they attempt to defraud insurers.

Our survey only measures American respondents. Increasingly, as our 2021 study and the work of the Global Insurance Fraud Summit, show that insurance fraud is now a global enterprise. A person wanting to commit insurance fraud against a U.S. carrier may be in the same city, or literally on the other side of the world seated at a laptop with an internet connection. Morals and ethics change from person to person and culture to culture. Part of what drives our moral and ethical decisions is the fear of being caught and held accountable for our actions. With global fraud, the risk of being caught and brought to any form of American justice or accountability for committing insurance fraud crimes, is virtually non-existent. Even within our nation's borders it is also evident through these responses that stronger anti-fraud laws are needed and far better communications of stories concerning convictions for insurance fraud crimes is needed if we are to deter especially younger American consumers from feeling it is okay to commit insurance fraud with little or no accountability or fear of being caught.



Reading this section has hopefully educated, enlightened and perhaps in a good way frightened you a bit about the psychology of how our fellow American citizens view insurance fraud. We selected these six questions to summarize because we felt they provided key insights into the almost never-ending facets of the responses we received in this study. With that in mind, and due to space, that means we failed to share with you the results of 14 more of the “core” insurance fraud psychology questions in this study. For those you will need to go to the appendix, which we very strongly urge you to do.

In the future, the Coalition, or perhaps others, will use this existing trove of data, and hopefully build upon it by adding more, to gain even deeper insights into our nation's insurance fraud psyche. Much in the same way as well will never be able to effectively fight insurance fraud until we can agree on its definition, we can also never hope to convince our fellow citizens to not commit insurance fraud, until

we understand the psychological beliefs they hold regarding the subject. This study builds upon the Coalition's efforts to do so since 1997 and is also a call for us, and for others, to continue this quest into the minds of consumers in the world of insurance fraud.

THE STUDY RESULTS – TIER TWO

Introduction

Having a stronger and deeper understanding of consumer attitudes toward insurance fraud is vitally important and formed the foundation for the first part of this study. The vast majority of Americans though will hopefully not commit insurance fraud and only a miniscule fraction of those consumers who do will ever be convicted for their fraudulent actions. But what about those who are caught and either admit their guilt or are convicted and sentenced? What motivated them to commit their criminal acts? Did they fully understand their actions, just naive, did they get caught up in a larger scheme or were they somehow seeking to “right” what they truly felt was a “wrong.” The second part of our study seeks to shed additional light on these and many other questions. The only way to truly try to understand the mind of a criminal fraudster is to let them tell you their story and we did just that to delve even deeper into the psychology of insurance fraud.

THE FOLLOWING CASE STUDIES ARE BASED ON ON-CAMERA INTERVIEWS WITH WILLING OFFENDERS OF INSURANCE FRAUD.



These cases range in severity from errors and lack of oversight to outright, intentional fraud. The insights gained from these interviews is invaluable and will better inform us all on how people can

rationalize insurance fraud. According to a recent study by the Coalition Against Insurance Fraud, insurance fraud costs the U.S. economy a record \$308.6 billion. Perhaps gaining an understanding as to why people engage in insurance fraud can help us determine the appropriate internal controls needed to prevent future occurrences.



THE FOLLOWING CASES ARE DETAILED AS FOLLOWS:

1. **Barry Mount**
2. **Courtney McMahon**
3. **Sean Enriques**
4. **Michael Sarubbi**
5. **Barbara Gonzalez**

Name	State	Year of Conviction	Type of Fraud
Barry Mount	Pennsylvania	2021	Insurance Fraud, Forgery, Unlawful Use of Computer and Tampering with Records or Identification
Courtney McMahon	Colorado		Health Care Fraud
Sean Enriques O'Keefe	San Diego	2014	Health Care Fraud
Michael Sarubbi	Pennsylvania	2020	Theft by deception, Conspiracy to commit theft by deception and Insurance fraud
Barbara Gonzalez	Florida	2023	Racketeering, grand theft and insurance fraud charges

These sample cases represent a pervasive problem. Often when people are faced with a problem, they will resort to any means necessary to solve it. If an organization's internal controls are lax, a person can create an opportunity to defraud any organization. As we know, no system is perfect; however, certain processes organizations put in place can cause some people to act unethically. A common theme noticed throughout many of these case interviews was the high denial of insurance claims. Barbara Gonzalez noted in her interview her belief that she was helping homeowners get claims through the system that would otherwise get denied.

However, in healthcare fraud cases, it appears that submitting insurance claims for medical procedures appears to be easier. Perhaps the reliance on doctors and attorneys appears to be a layer of protection embedded in the process to prevent health care fraud; however, when the medical professionals are compromised, it makes fraud easier to execute.

As you read these cases, you will notice that their fraud intentions vary. Some of the case perpetrators were intentional, masterminds behind an orchestrated scheme. Others were either following their boss's orders and found themselves in a difficult decision that led them to commit fraud, or trying to help others get through the complex insurance claims process.

Overall, the case studies offer an inside look at how easily insurance fraud can occur, the whistleblowers needed to detect fraud, and the future internal controls companies must implement to stop it.

BARRY MOUNT: FRAUD OR FAILURE TO READ THE NOT-SO-FINE PRINT?



INTRODUCTION



Barry Mount faced charges of insurance fraud, forgery, unlawful use of computers, and tampering with records or identification for attempting to defraud Glacier Insurance Company. The criminal case alleges that Barry submitted an altered version of a declarations page in an attempt to convince Glacier that his policy covered rental cars when, in fact, it had an exclusion for rental coverage.



THE ISSUE

While on a family vacation in Wildwood, NJ, he passed out while driving his rental car.

Earlier that day, Barry had an accident and flipped over on a jet ski. It's possible that his passing out occurred as a consequence of the jet ski accident. In any case, Barry narrowly avoided a pole hole and hit two parked cars resulting in thousands of dollars in damages.



Barry immediately filed a claim with his car insurance company, Glacier Insurance. It did not even occur to Barry that the policy excluded rental vehicles. His mother once had a car accident in Barry's old car, and her policy covered rental vehicles. Therefore, that was his only reference he had on the issue, which led him to improperly assume he had rental coverage when he did not.

When renting the car, Barry provided the rental company with a copy of his car insurance policy, including the declarations page. Barry should have realized that, as stated on the declarations page, his personal policy did not cover car rentals. Barry stated that the declarations page was blurry when he printed it for the rental car company and this was another reason he was unaware that rental car coverage was excluded.

Ultimately, Barry knew he was responsible for signing up for rental coverage from the car rental company. It is offered at an additional cost at the time of rental. However, Barry did not sign up for rental coverage because he assumed he was covered.



The insurance company immediately rejected Barry's claim and accused him of attempting to commit insurance fraud for filing such a claim. Barry became very scared about such accusations and hired a lawyer. But nothing happened until, a year later, the FBI came knocking.



THE RESOLUTION

With the advice of counsel, Barry accepted a program called the "Accelerated Rehabilitative Disposition (ARD) Program." ARD is a unique program approved by the Supreme Court of Pennsylvania, generally for first-time offenders with no prior criminal convictions or prior ARD dispositions. In Pennsylvania, ARD is supervised by the ARD Chief, who reviews criminal cases for potential admission. ARD is a discretionary program managed exclusively by the Office of the District Attorney; therefore, the District Attorney is the sole authority regarding who gets into the ARD program.



The primary purpose of the ARD program is the prompt disposition of charges, eliminating the need for costly and time-consuming trials and other court proceedings. The program is designed to recognize offenders amenable to treatment and rehabilitation and effectively remove their cases from the criminal justice system, freeing resources better used elsewhere. Upon completing the ARD program, people may petition the court to expunge their records.

For Barry, ARD meant receiving one year of unsupervised release, 10 hours of community service, and a fine. Despite an outcome excluding jail time, Barry and his family appear bitter over the conviction and how the ordeal unfolded. The investigation was an extremely stressful time for Barry.

He had never been in trouble with the law and felt as though his error didn't warrant the punishment he received. Barry and his family feel that making him a convicted felon over this discrepancy is unfair. The insurance company viewed Barry's case as intentional because the Declarations page states in plain black and white that there is no rental coverage. Barry maintains that he had nothing to gain from filing a false claim; his mistake was mainly an oversight. But that excuse rings hollow for the victims of a car accident and the insurance companies involved. The insurance company likely referred Barry's case for investigation and prosecution to make an example out of him. These cases have real-world consequences. The consequences of failing to secure rental coverage can be substantial. In Barry's case, the parked cars were damaged to the tune of tens of thousands of dollars.

To this day, Barry is trying to manage his anxiety and put his life back on the right track.



BECOMING BARRY

Rental car insurance is available through a personal insurance policy, credit card benefits, or from the rental car company itself. Depending on the policy, rental car insurance may cover damage to the vehicle, damage or injuries to another or self, theft, and loss of personal items. The most common types of rental car insurance are liability, collision damage waiver, personal accident, and personal effects.

On average, rental car insurance costs \$61 per day, but it depends on the amount of coverage purchased, among other things. A person's personal car insurance, health insurance, and credit card benefits will usually provide coverage when renting a car. Other alternatives to rental car insurance are non-owner car insurance, temporary car insurance, and travel insurance. According to WalletHub, rental car insurance is rarely worth it if a personal vehicle is insured and the rental car is paid with a credit card. Still, failure to understand their insurance coverage is a common problem. Common sense and our own personal experience indicate that people do not read or comb through the details of their car insurance policies or other consumer contracts of adhesion.

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INTRODUCTION



Beginning in 2014, the Department of Justice (“DOJ”) revealed a criminal scheme spanning 15 years and cumulatively totaling more than \$950 million. The scheme involved \$40 million in illegal kickbacks paid to doctors, lawyers, and other medical professionals in exchange for referring thousands of patients for surgeries at California hospitals.

Healthcare kickbacks are illegal because, among other things, they corrupt the doctor-patient relationship and may encourage medical professionals to recommend procedures that are not necessary, not in the patients’ best interest or even harmful.

Sean Enriquez, once a certified Worker’s Compensation attorney in California, was involved with two of the leading architects of the scheme:

- Michael Drobot, the former owner of Pacific Hospital in Long Beach, CA, is considered a mastermind; and
- Paul Randall, another principal figure in the scheme, and whose cooperation with the federal government unraveled the entire operation.



THE ISSUE

Sean had a successful, profitable Workers Comp practice in Southern California and lived a comfortable life. In his practice, the issue of bribes and kickbacks often came up. However, over the decades he devoted to practicing Workers Comp law, he had always steered clear.

Until he didn’t.

Around 2011, a neurosurgeon friend, who was a certified back specialist, told Sean that he could make \$15,000 per referral from a successful physician named Mike Drobot. Drobot owned a small private hospital in Long Beach, CA, and he was offering to pay \$15,000 per referral for spine surgery. Sean did the math, quickly realizing that this arrangement would mean an extra \$900,000 or so a year. Greed and stress – which Sean managed with heavy drinking – got the better of Sean’s judgment.

Sean reports that from 2006-2012 he had the largest Workers Comp practice in his area. But beginning around 2010/2011, he was drinking heavily and going through marital troubles. His personal situation led him to make self-destructive decisions, including getting involved with Drobot and accepting kickbacks. The amount was the highest he'd ever been offered. He knew it was wrong. He knew it was illegal. He had turned his back on those offers for a long time, he says. This time was different.

Did Sean need the money? No. He owned his home on the waterfront. He drove luxury cars like Mercedes. He owned boats. He worked less than 2 hours per day. At its height, Sean says his practice reported over \$1.5 million in gross income. His take-home pay was at least \$500,000 to \$600,000. It made no logical sense to risk that. Still, he made "the worst decision of my life."

"I went from a humanistic, kind, generous lawyer," Sean says, to a "greedy and criminal one. "Greed can be as intoxicating as alcohol." That's the only explanation he can come up with for his self-destructive behavior in this case.

In our interview, Sean admitted that it was a criminal conspiracy and not just normal professional networking or standard referrals. "The doctor and I had an alignment of interest. He got paid, and I got paid. The hospital got paid, I got paid. It was a 3-cornered transaction."

As a workers comp certified attorney, Sean was to look out for the client's best interest. Many injured patients start their journey at a lawyer's office, seeking advice and compensation for legitimate injuries on the job. Sean says all of his clients had legitimate injuries. "The patients came to me. and as part of my job, I would refer the patients to physicians."

It is a fine line between normal professional referrals and steering business for kickbacks. Everyone involved – lawyer, doctor, hospital – has a duty to work for the best interest of the patient/client. Referrals based on the fact that you expect to receive a kickback is illegal and wrong.

"Medical referrals should be based on what's best for the patient – not what's best for the doctor's bank account," said IRS-Criminal Investigation Special Agent in Charge Erick Martinez. "In paying the kickbacks and submitting the resulting claims for spinal surgeries and medical services, the defendants acted with the intent to defraud workers' compensation insurance carriers and to deprive the patients of their right to honest services."

When Sean was arrested in August 2014, he quickly admitted his wrongdoing and cooperated. Upon arrest, his strategy was to cooperate early and cooperate often. Sean was on damning recordings that the FBI had obtained from Paul Randall.

"I needed to cooperate," he stated during his interview. "I got lucky to have the chance early in the process to offer them a lot of information." As a cooperating witness and lawyer, Sean knew what they wanted and needed. He offered to explain the system to them and to a potential jury. He wore a wire and recorded a few dozen doctors and others, he told us.

Ultimately, Sean was sentenced to 15 months in prison.



THE SCHEME:

Drobot was charged in a long-running healthcare fraud scheme that involved tens of millions of dollars in illegal kickbacks in exchange for referrals of thousands of patients who received spinal surgeries.

Sean was just one of Drobot's funnels.

Per the government, the referrals to Drobot's hospital led to hundreds of millions in bills being fraudulently submitted during the last five years of the scheme alone, much of which was paid by the California worker's compensation system.

The government's official version of the scheme is not that different from what Sean shared about his experience in the case (see references below):

- From 1997 to 2013, Drobot, owner of Pacific Hospital ran a scheme in which he billed workers' compensation insurers hundreds of millions of dollars for spinal surgeries performed on patients who had been referred by dozens of doctors, chiropractors and others who were paid illegal kickbacks.
- For referrals for spinal surgeries, Drobot typically paid a kickback of \$15,000 per lumbar fusion surgery and \$10,000 per cervical fusion surgery. Some of the patients lived as much as hundreds of miles away from Pacific Hospital, and closer to other qualified medical facilities. The patients were not informed that the medical professionals had been offered kickbacks to induce them to refer the surgeries to Pacific Hospital.
- Drobot and his co-conspirators concealed the kickback payments by entering into bogus contracts with the doctors, chiropractors, and others who received kickbacks. In reality, the contracts merely provided a cover story for the kickback payments. The kickbacks were financed largely by money generated from inflated prices for medical devices implanted into state workers' comp patients during spinal surgeries.
- Drobot set up a scheme based on a now-repealed California law known as the spinal "pass-through" legislation, which permitted hospitals to pass on to workers' comp insurers the full cost of medical devices implanted in spinal surgery patients.
- Specifically, Drobot used shell companies to inflate the costs of those devices and then billed

the insurers at the inflated rates. “The spinal pass-through, the provision of California law that allowed Pacific Hospital to fraudulently inflate the cost of the medical hardware used during spinal surgeries, was a vital component of defendant Drobot’s ability to pay kickbacks to the doctors, chiropractors, marketers, and others who had referred patients to Pacific Hospital for surgeries and other medical services,” according to the charging documents.

- To protect this legal loophole, Drobot also paid bribes to California State Senator Ronald Calderon in exchange for Calderon performing official acts to keep the spinal pass-through law on the books.
- Calderon was indicted on federal charges for allegedly accepting bribes from Drobot, as well as undercover FBI agents seeking official acts in relation to other matters.

Sean explained how easy this was for Drobot to manipulate the California Workers Comp system. Doctors’ fees are controlled by a reasonably generous medical fee schedule (as compared to Medicaid and Medicare). Recommending lucrative spinal surgery is not hard for a doctor to justify. After an injury, an MRI will always show some amount of disc degeneration. A certified neurosurgeon can easily justify within the system guidelines that a case is surgical and the patient needs spinal fusion.

Workers comp would pay approximately \$105,000 to \$115,000 just for spinal surgery. The lead surgeon is guaranteed to receive at least \$15,000 plus revenue from pre-surgery and follow-up care. A hospital hosting the surgery is guaranteed from \$45,000 to \$60,000. The rest is spread out among other service providers, leaving plenty of room for paying healthy kickbacks. Perhaps to maximize his ability to monetize, Drobot’s hospital did nothing but spinal surgery and related services.



Paul Randall was a healthcare marketer who admitted recruiting chiropractors and doctors to refer patients to his hospitals in exchange for kickbacks. His admissions launched “Operation Spinal Cap” – investigating the kickback schemes, which involved dozens of surgeons, orthopedic specialists, chiropractors, marketers, and other medical professionals.

Paul Randall worked with Mike Drobot at Pacific Hospital before moving to other hospitals. According to Sean, Paul adopted very aggressive billing practices at a new hospital and this put him under scrutiny. That investigation led Paul to reveal all of his involvement with others.

According to Sean, the investigation resulted in hundreds of cases, 44 public indictments, 41 guilty pleas, 3 trials, and 3 trial convictions.

Operation Spinal Cap revealed that hospitals were not only kickbacks but overbilling for spinal hardware used in surgeries. Regrettably, in many instances, dangerous counterfeit hardware was

implanted into the backs of unsuspecting patients. According to investigators, counterfeit screws were mixed with FDA-approved screws made by a reputable medical device company from South Korea.



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COURTNEY MCMAHON: A BROKEN SYSTEM



INTRODUCTION



Courtney McMahon's health insurance fraud case stems from a 2015 car accident involving her boyfriend. When it happened, Courtney's educational and professional background made her all too familiar with the difficulties people can experience getting medical coverage in personal injury cases.

Unfortunately, Courtney decided to take matters into her own hands and manipulate the paperwork needed to approve coverage. When asked to explain her reasons, Courtney cited an opioid addiction, financial desperation, and utter

disappointment with the broken system governing medical insurance in personal injury cases.

Courtney's actions led to insurance fraud charges for creating fictitious documents to extract insurance payouts.



Courtney's case was not a failure to understand or know the rules. In fact, Courtney knew them all too well. She is a well-educated woman with a seemingly good head on her shoulder. Courtney's formal education includes two bachelor's degrees and a master's.

Courtney's long history working in personal injury law and medical billing also informed her actions. Her personal history in a car accident also played an essential role in defining her actions. Several years ago, when Courtney had been in a car accident she experienced financial struggles for lack of proper coverage and reimbursements. She also ended up addicted to pain killers.

Thus, when the insurance company in her boyfriend's case denied large chunks of his claims (offering approximately \$11,000 in a case where the medical costs alone totaled \$33,000), Courtney felt a rightful indignation at the unfairness. It didn't help that, at the time, she was spending all of her money on satisfying her addiction to opioids, which exacerbated everything. Courtney decided she had the only option for them was for her to manufacture false documentation to support her boyfriend's claims—presenting them in a way that would get approved for insurance coverage.

This is not to say that Courtney's judgment was not clouded when she chose to commit insurance fraud. Her thinking was absolutely clouded, as she was in active addiction. So on a very human level, she feels she did not make an intentional, conscious decision to commit a crime. During the interview, she commented that she did not feel evil, criminal or antisocial. "I was compromised by opioid addiction; my judgment was impaired", she recalls. Courtney's addiction led to her getting fired from her medical billing job for stealing prescription pads to write herself scripts for opioids.

Based on Courtney's experience, she had seen her fair share of insurance companies denying claims. "If the insurance companies claim that the doctor ordered unnecessary services, they can whittle away the victim's compensation in a given case". From her experience, companies also try to exclude costs associated with pre-existing conditions. "The fact that insurance companies can reduce claims arbitrarily", says Courtney, "renders the system inadequate and ineffective for most people".

After Courtney submitted the manufactured documents, the insurance adjuster became suspicious based on a noticeable medical coding error. The adjuster was also aware of Courtney's background

as a medical biller for many years.

When the insurance adjuster began asking probing questions about the discrepancies, Courtney panicked, but she did not back down.

Two years passed with no word, but then Courtney got a call from the Attorney General's office. She was not surprised. In her mind it was only a matter of time before someone came around asking questions again. She immediately admitted guilt, and her prosecution began.

Courtney suffered less severe consequences than most fraud offenders in her position because she quickly took accountability for her actions. She faced no jail time, no fine, or restitution. Her main penalty was two years of probation. Still, she now lives as a convicted felon and all the attendant consequences.

Her case is similar to many other cases of medical billing insurance fraud and the consequences are serious. Common medical billing fraud cases include

- Billing for services never performed billing for medically unnecessary procedures:
- Falsifying a patient's diagnosis to justify the need for tests, surgeries, or other procedures that are not medically necessary; or
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery.

Fines, restitution, and prison time usually accompany this type of fraud and Courtney was lucky she eluded such penalties. Her outcome was largely based on her willingness to come forward right away and admit her action, thereby saving the government enormous time and expenses to prosecute her case.

MICHAEL SARUBBI: HEALTHCARE FRAUD CONSPIRACY



INTRODUCTION



In 2019, 11 people and nine businesses were charged in a massive insurance fraud scheme following a Pennsylvania grand jury investigation into Liberation Way. When it was all said and done, Liberation Way's CEO and others pleaded guilty for their roles in the \$17 million fraud. The prosecutors maintain that Liberation Way was a phony addiction treatment center.

But for Michael Sarubbi, who had a personal history of substance abuse, addiction, treatment, and recovery, the work he did there was anything but phony. It was meaningful. It came from a deep commitment and passion for helping others overcome addiction through treatment.

Before joining the founders of Liberation Way, Michael spent years volunteering at treatment centers and other organizations. He also invested to help a treatment center in NJ that he also helped run for many years.

The opportunity to work with the founders of Liberation Way was attractive to Michael. It offered a good income while doing something for which he felt deep devotion.

Today, Michael admits that, although he did not realize it then, Liberation Way turned out to be run by money grabbers, people more interested in making a quick buck than genuinely helping people. The sooner the center could turn a profit, the sooner it could be sold to investors for tens of millions.

Indeed, to hear investigators tell the story, Liberation Way was a fraudulent substance abuse center established for the primary purpose of overbilling insurers, not to provide adequate treatment.



According to AG Shapiro, Liberation Way was nothing more than “a highly sophisticated insurance fraud that exploited people with addictions.” The scheme was to get addicts into treatment to bilk insurers who covered their treatment. If the addicts were not covered by insurance, Liberation Way arranged to sign them up for policies that would pay for their services.

As CEO, Jason Gerner oversaw a business that illegally secured insurance policies for patients, then overbilled insurers for substandard or medically unnecessary treatment. The company overbilled insurers between July 2015 and early 2018 to the tune of more than \$17 million.

Many, if not most, of the treatment center’s patients lacked insurance policies that properly covered inpatient rehabilitation. Liberation Way illegally secured and paid premiums for patients’ insurance policies. In turn, the company would overbill insurers for medically unnecessary, poor, or sometimes non-existent treatment. Investigators claimed to have evidence that patient policies were often secured with fraudulent information so that patients qualified for “platinum” coverage. As such, Liberation Way would qualify to receive the highest possible insurance reimbursement.

The scheme also included kickbacks from overbilling insurers for thousands of medically unnecessary urine tests handled by a Florida laboratory. And at least one physician, Dr. Ramesh

Sarvaiya, was charged with conspiring to commit healthcare fraud. Sarvaiya allowed Liberation Way to use his identification code in submitting fraudulent bills to insurers for more than \$9.5 million.

Investigators described Michael Sarubbi as “a Liberation Way employee who disguised the source of money used to pay for patients’ insurance policies, so the company was not directly linked to the policies.”

In sum, Gerner and his colleagues were accused of, among other things,

- fraudulently purchased premium insurance policies on behalf of patients so that Liberation Way could bill for expensive treatments that were never provided;
- ordering tests and treatments for patients who their doctors never saw;
- paying a doctor to sign urine testing orders for patients who were never seen;
- receiving kickbacks from laboratories;
- and conspiring to hide proceeds received from kickbacks.

Michael does not deny that at Liberation Way, a big part of his work was to help people get into treatment and obtain health insurance if necessary so they could remain in treatment for the proper amount of time. Above all, he cared about the people, their substance abuse issues, and their treatment needs. If he got a call for help, he would first get someone to a facility where they could start getting help immediately, whether they had insurance or not.

According to Michael, with the advent of the Affordable Care Act, opportunities opened up to help more people obtain health insurance to cover substance abuse treatment. As Michael became more versed in the area, he helped many families through the process. He intended to help people obtain complete treatment. He never wanted to see someone get kicked out of treatment prematurely because of insurance.

At some point, the issue arose of whether helping people sign up for health insurance or help them pay their premiums was legally acceptable. The company sought a legal opinion, and Michael believed that the company’s practices were in the clear. Liberation Way had set up a nonprofit arm to help families and patients navigate the insurance coverage process so that patients could obtain and remain in treatment. But according to the criminal charges, what Liberation Way did in that regard was illegal.

Indeed, Michael recalls the day the CFO told him the company wanted him to cash a check for \$13,000 and then write a check back to the nonprofit. Michael felt uneasy, but it was presented as a non-negotiable. Do this or lose your job.

He candidly admits that the idea of losing his job and income was untenable at that moment. He

admits to greed, but also states he did not want to stop helping people get treatment. Those checks would come back to haunt him in the later criminal investigation.

For his role, prosecutors sought to charge Michael under the Racketeer Influenced and Corrupt Organization Act (RICO), including receiving proceeds from a corrupt organization.

He came to learn that the company owners and founders were involved in massive billing fraud and kickbacks. Michael was not involved and did not know about those activities. Still, his lawyer told him he was looking at a federal case that could send him to prison for 8 to 12 years if he lost at trial. Michael's reliance on the legal opinions that he thought cleared the company was misguided. The legal opinions had nothing to do with the charges at hand and provided no comfort.

In the end, Michael's cooperation led to partial immunity. His personal history of helping his community in the addiction and recovery arena helped avoid the harshest penalties. He pleaded guilty to theft by deception, insurance fraud, and conspiracy but did not face prison time, restitution, or forfeiture. The judge sentenced him to four years of probation.

Michael followed the orders from his company CFO to participate in an exchange of funds that proved to be highly unethical and illegal. It was not something he set out to do himself. He was asked to do it to benefit the company.

In addition, Michael acted out of an intense desire to help addicts obtain treatment. He has tremendous compassion for people who lack the means to get adequate help with substance abuse. Having been down the road to recovery and sobriety himself, Michael feels he has much to offer in this arena. His mindset all along was that he wanted to help people.

Michael saw the holes in the healthcare insurance process. Lack of adequate insurance exacerbates the pain for families with people in active addiction.



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BARBARA GONZALEZ, OPERATION: CROSSING THE RUBICON



INTRODUCTION



On April 30, 2019, authorities announced the arrest of a public adjuster and 35 others involved in a massive insurance fraud scheme that targeted Citizens and other insurance companies. The operation, called 'Crossing the Rubicon' was the culmination of a year-and-a-half-long investigation into the Rubicon Group and their affiliates. Text messages and emails between representatives of the Rubicon Group and eight others within a fraudulent network discussed the planning, staging, and reporting of insurance claims to Citizens and other carriers resulting in 100 suspected fraudulent claims.

This interview was conducted while Barbara was awaiting prison to serve her three-year prison sentence.



THE SCHEME

Barbara Gonzalez was a licensed public adjuster based in Miami, Florida. Barbara operated the Rubicon Group, a public adjusting firm with her father, ex-husband Lt. Alexander Diaz de Villegas, and seven others. The Rubicon Group's role was advocating for homeowners in appraising and negotiating claims, which typically resulted in the Rubicon Group receiving a cut of any settlement. For the scheme to be successful, homeowners, contractors, appraisers, water mitigation and restoration services, and insurance agents were recruited and had to cooperate and agree with the entire process.

After a homeowner agreed to the scheme, a recruited plumber would damage the homeowner's property. The plumber would then ask a complicit adjuster and an insurance agent to help increase coverage on the homeowner's policy or, in some cases, create an insurance policy for an uninsured

homeowner. In some instances, the plumber would break or damage an item so that the coverage would be for a larger amount (as opposed to a smaller area in the home). For example, a plumber could break water pipes to make it look like a flood or bring water into the home to increase the insurance claim. Staging insurance losses bilked or attempted to bilk Citizens Property Insurance Corp. and perhaps other insurers out of more than \$600,000, according to court records and news reports.

Although numerous attempts were made to ask Barbara questions about the scheme, she was unwilling to answer many of the details. She denied being the mastermind and cited a broken insurance system as the reason she felt the need to help homeowners. “Most claims are denied,” Barbara explained, “and I was helping homeowners who may otherwise have the claims denied.”

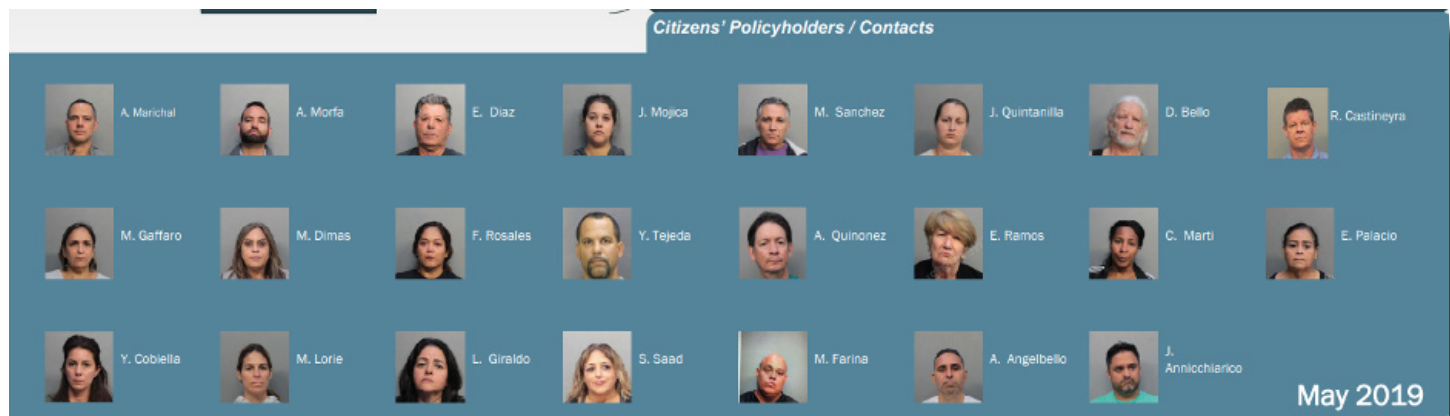
Figure 1: The Rubicon Group Employees



As the diagram indicates, this was a well-orchestrated scheme supported by many.

In addition to the scheme, what is also surprising are the profiles of the homeowners willing to participate. Many of the homeowners were first-time offenders insured by Citizens Insurance.

Figure 2: Citizen's Policyholders



According to the Miami-Dade police, Barbara allegedly helped her one-time lover Felix Bravo, also charged, file a fake \$75,000 claim of water damage to his house in January 2017. When the insurance company investigated, they found that the plumber who supposedly fixed the damage didn't exist, and the receipt submitted was fake, according to the arrest report.

In another instance, she and her ex-husband Miami-Dade Police Lt. Alexander Diaz de Villegas, submitted phony documents to get over \$100,000 from an insurance company for three separate damage claims dating back to 2013, according to the evidence. Ultimately, Diaz de Villegas reported his wife and exposed the fraud. He provided a statement that Barbara committed fraud on his personal claim. Barbara Gonzalez faces racketeering, grand theft, and insurance fraud charges, with charges pending for the other participants.

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CONCLUSIONS AND TAKE-AWAYS

My recent book, (Fool Me Once: Scams, Stories, and Secrets from the Trillion Dollar Fraud Industry, Harvard Business Review Press, March 2023), examines the rising cases of fraud in the U.S. and explores some motivations for committing white-collar crimes. Through my years of research, I noticed that not all fraud perpetrators are created equally. Thus, in Fool Me Once, I set forth three archetypes for fraud offenders, highlighting the different reasons a person may fall into fraud. I studied the Intentional, Accidental, and Righteous Perpetrators.

Figure 3: Fool Me Once Fraud Archetypes

INTENTIONAL PERPETRATORS	ACCIDENTAL PERPETRATORS	RIGHTEOUS PERPETRATORS
<ul style="list-style-type: none">• Focus on enriching themselves• Operate as if rules don't apply to them• Thrive in environments with lax internal controls	<ul style="list-style-type: none">• A mistake/oversight made by another person that opens the door for crime• Tend not to speak up and tend to avoid confrontation• Often follow the orders of a superior	<ul style="list-style-type: none">• Follow the Robin Hood syndrome• Use company resources to aid those outside the workplace

Source: Fool Me Once: Scams, Stories, and Secrets from the Trillion Dollar Fraud Industry, Harvard Business Review Press, March 2023

The insurance fraud cases detailed above run the gamut. After completing the interviews, I decided to organize the insurance fraud cases and place them into the various fraud archetypes from Fool Me Once.

Figure 4: Insurance Fraud Cases Analyzed by Fraud Archetypes

Name	State	Year of Conviction	Type of Fraud	Fraud Archetypes
Barry Mount	Pennsylvania	2021	Insurance Fraud, Forgery, Unlawful Use of Computer and Tampering with Records or Identification	Accidental Perpetrator
Courtney McMahon	Colorado		Health Care Fraud	Righteous Perpetrator
Sean <u>Enriques O'Keefe</u>	San Diego	2014	Health Care Fraud	Intentional Perpetrator
Michael <u>Sarubbi</u>	Pennsylvania	2020	Theft by deception, Conspiracy to commit theft by deception, and Insurance fraud	Accidental Perpetrator
Barbara Gonzalez	Florida	2023	Racketeering, grand theft, and insurance fraud charges	Intentional Perpetrator

During both interviews with Barry Mount and Michael Sarubbi, I categorized their cases in the Accidental Perpetrator category, with Barry's case being more accidental than Michael's. Both of their frauds resulted from a set of circumstances they did not initiate. Barry did not either fully review or misunderstood the rental coverage on his rental car. Based on my research, his crime appeared to start as an error. When the insurance company contacted him, he was completely shocked, confused and unaware that he had done anything wrong. Michael's case, however, is a great example of what can happen when employees work for unethical leadership. Michael was asked to participate in a fraudulent scheme and believed he had no option but to comply. Sean Enriques O'Keefe and Barbara Gonzalez are Intentional Perpetrators. Based on the case evidence, Barbara's company was set up to defraud insurance companies. She understood the system and manipulated the insurance claims process for personal gain. She showed little remorse for her crime and had numerous co-conspirators to help her execute a massive fraud. Sean, however, did have a successful law practice before deciding to accept bribes and kickbacks. Sean knew the worker's compensation claims process exceptionally well and utilized his knowledge to manipulate the system for personal gain. Sean appeared to be remorseful for his misdeeds and now seeks to educate people about the ins and outs of healthcare fraud. Courtney McMahon's case was the only case placed in the righteous category. She used her knowledge of the insurance claim process to help another person. When she realized that insurance would not adequately cover her boyfriend's medical needs, she willingly altered his paperwork to help. Although Courtney committed a crime, her actions were borne out of a deep sense of unfairness and the need to help someone else.

Understanding the issues, the schemes, and the various types of fraud offenders, can help companies better combat the proliferation of insurance fraud. Although curtailing the intentional perpetrators is much harder, the risks posed by accidental and righteous perpetrators can be managed with proper internal controls and training.

CONCLUSION

When the Research and Executive Committees of the Coalition Against Insurance Fraud approved proceeding with this study, and enlisted the support of our partner Verisk, we collectively knew the task ahead was arduous. How do you get inside the minds of an increasingly diverse American society to understand how they view insurance fraud and what may motivate them to actively participate in such crimes? What are the correct questions, how do you structure a study to make sure respondents fully understand the scope of insurance fraud and the implications of the answers they are providing? And in the second part of our study, how do you convince those who have been caught and either pled or been found guilty of insurance crimes to allow you to understand the "how" and "why" of their criminal actions? At no point in this study was there ever an easy answer or shortcut. Our leaders and partners also understand the impact and importance when the Coalition takes on the task of conducting the most extensive analysis of the psychological insights of insurance fraud that has ever been conducted.

We believe we succeeded, but the final tests will be you and time. Success though only comes through the knowledge, skills, dedication and commitments provided by our strategic partners and our Coalition leadership. Like all of our studies, we conceived, developed, conducted and are now reporting these findings solely for the purpose of empowering you to better fight against all forms of insurance fraud. Those seeking to commit insurance fraud crimes are the enemies of all honest policyholders and insurance carriers alike. Commander Oliver Perry famously said, “We have the enemy and they are ours.” By understanding the psychology of those seeking to commit insurance crimes, we hope this study provides you a far greater depth of understanding of who those “enemies” of good and honesty are so you are better equipped to combat insurance fraud in the years and decades ahead.

APPENDIX





INTRODUCTION

In the course of conducting our comprehensive study on why an increasing number of Americans believe insurance fraud is not a crime, we recognized the importance of analyzing the demographics of individuals involved in fraudulent activities. By examining the characteristics and backgrounds of these individuals, we aim to gain a deeper understanding of the factors that may contribute to insurance fraud. This appendix presents a breakdown of key demographic variables, along with the full results of the survey.

To facilitate a comprehensive analysis, we have separated the demographic data into various subcategories, which are presented below:

Age	Gender:	Marital Status:	Political View:
18-24	Male	Married	Conservative
25-34	Female	Single	Progressive
35-44		Cohabiting	Independent
45-54		Separated/Divorced	I prefer not to answer
55-64		Widowed/widower	
65+		Prefer not to say	

Regions:	Residential Area:	Income:
WEST	Rural	Less than \$25,000
SOUTH	Suburban	\$25,000 to \$49,999
MIDWEST	Urban/City	\$50,000 to \$74,999
NORTHEAST	Other	\$75,000 to \$99,999
		\$100,000 to \$149,999
		\$150,000 to \$199,999
		\$200,000+

Ethnicity: Are you of Hispanic/Latino origin?
Yes
No
Ethnicity: What is your race or ethnic background?
White or Caucasian
Black or African American
Asian
American Indian, Alaska Native, Native Hawaiian, or <u>other</u> Pacific Islander
Some other ethnicity (please specify)
What is the highest level of education that you completed?
Did not complete high school
High school graduate or GED
Some college, no degree
Associate's or Bachelor's degree
Post graduate degree

Please refer to the following pages for the results of all questions asked during the study.

Have you been directly involved (alone or with another member of your household) in making decisions to buy or renew any form of insurance?

All respondents

Yes

1505

100%

Question 1

We asked consumers seven different questions to gather their opinions on trust, respect, and how insurance companies overall treat their customers.

Overall, respondents believe insurance companies treat their customers fairly and that most people ultimately tell the truth when submitting insurance applications.

Please indicate how much you agree with each of the statements below.

(Please rank in order the following statements to indicate how much you agree with each. Rank choices from 1 complete agreement to 7 complete disagreement)

Overall, insurance companies treat their customers fairly	1	507	33.69%
	2	194	12.89%
	3	165	10.96%
	4	154	10.23%
	5	133	8.84%
	6	144	9.57%
	7	208	13.82%
Overall insurance companies' procedures to set premiums are fair and applied consistently	1	190	12.62%
	2	306	20.33%
	3	274	18.21%
	4	216	14.35%
	5	216	14.35%
	6	195	12.96%
	7	108	7.18%
Overall, the claims that insurance companies pay are fair to policyholders	1	143	9.50%
	2	276	18.34%
	3	366	24.32%
	4	252	16.74%
	5	240	15.95%
	6	147	9.77%
	7	81	5.38%
Insurance companies make too much money at the consumer's expense	1	439	29.17%
	2	196	13.02%
	3	160	10.63%
	4	252	16.74%
	5	212	14.09%
	6	129	8.57%
	7	117	7.77%
If insurance companies treated people with more respect, there wouldn't be as much insurance fraud	1	77	5.12%
	2	206	13.69%
	3	213	14.15%
	4	234	15.55%
	5	297	19.73%
	6	320	21.26%
	7	158	10.50%
Nobody tells the whole truth on their insurance application	1	41	2.72%
	2	103	6.84%
	3	152	10.10%
	4	185	12.29%
	5	214	14.22%
	6	340	22.59%
	7	470	31.23%
Insurance rates are based on the assumption that there will be fraud	1	108	7.18%
	2	224	14.88%
	3	175	11.63%
	4	212	14.09%
	5	193	12.82%
	6	230	15.28%
	7	363	24.12%

Question 2

We asked consumers their opinion on who pays the most for insurance fraud. Respondents tend to think government agencies pay the most for insurance fraud. However, they believe policyholders pay the least.

Who pays the most for the cost of insurance fraud?

(Rank 1 as the lowest payer for insurance fraud to 4 as the highest payer of fraud cost)

Insurance companies	1	324	21.53%
	2	449	29.83%
	3	468	31.10%
	4	264	17.54%
Policyholders	1	842	55.95%
	2	241	16.01%
	3	220	14.62%
	4	202	13.42%
People making claims under insurance policies	1	193	12.82%
	2	597	39.67%
	3	464	30.83%
	4	251	16.68%
Government agencies (state or federal)	1	146	9.70%
	2	218	14.49%
	3	353	23.46%
	4	788	52.36%

Question 3

We asked consumers their opinion on why insurance fraud occurs.

Respondents feel improper actions by insurance companies ranked as one of the primary reasons, along with normally honest people feeling they are forced to commit fraud to receive fair payment.

The primary reason insurance fraud occurs is:

(Rank 1 as the least likely reason to commit fraud to 4 as the most likely to cause fraud)

Improper actions by insurance companies	1	272	18.07%
	2	326	21.66%
	3	425	28.24%
	4	482	32.03%
Greedy people seeking unfair compensation	1	742	49.30%
	2	298	19.80%
	3	242	16.08%
	4	223	14.82%
Normally honest persons feeling they are forced to commit fraud to receive fair payment	1	238	15.81%
	2	300	19.93%
	3	494	32.82%
	4	473	31.43%
Dishonest attorneys, contractors, medical providers, or similar professionals encouraging fraud	1	253	16.81%
	2	581	38.60%
	3	344	22.86%
	4	327	21.73%

Question 4

We asked consumers their opinion of the insurance industry's focus on the commitment and ability to detect fraud.

Respondents believe insurance companies aren't highly skilled at detecting fraud.

When it comes to identifying fraudulent claims:

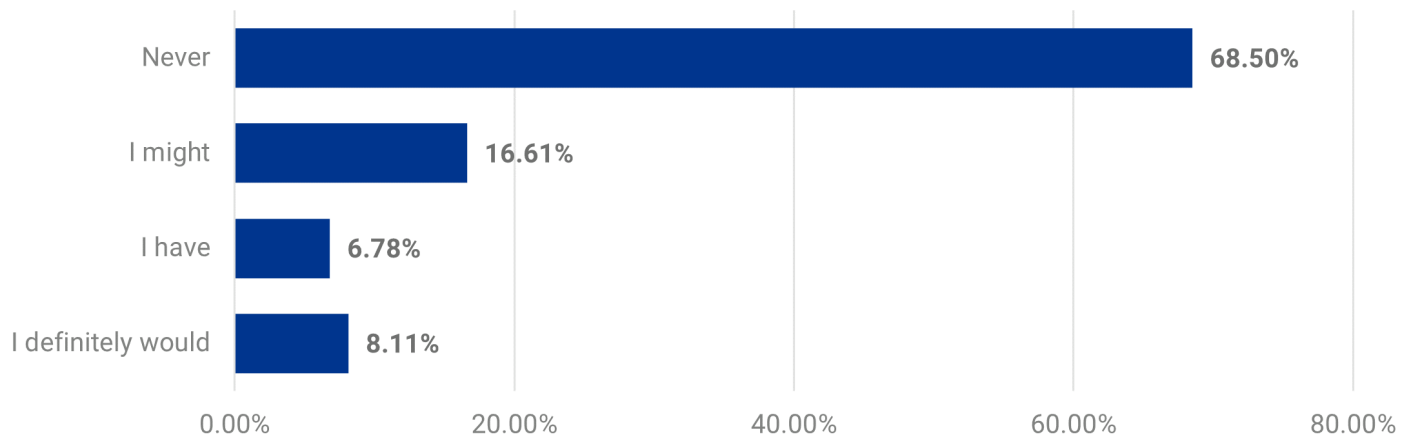
(Rank your responses from 1 being the statement you least agree with to 4 being the one you most agree with)

Insurance companies are highly skilled and catch most fraud	1	515	34.22%
	2	314	20.86%
	3	318	21.13%
	4	358	23.79%
There is so much fraud insurance companies only catch a very small amount of it	1	497	33.02%
	2	382	25.38%
	3	359	23.85%
	4	267	17.74%
Insurance companies are not really committed to even trying to identify fraud	1	276	18.34%
	2	371	24.65%
	3	413	27.44%
	4	445	29.57%
Insurance companies would catch more fraud if they had more money and personnel to investigate it	1	217	14.42%
	2	438	29.10%
	3	415	27.57%
	4	435	28.90%

Question 5

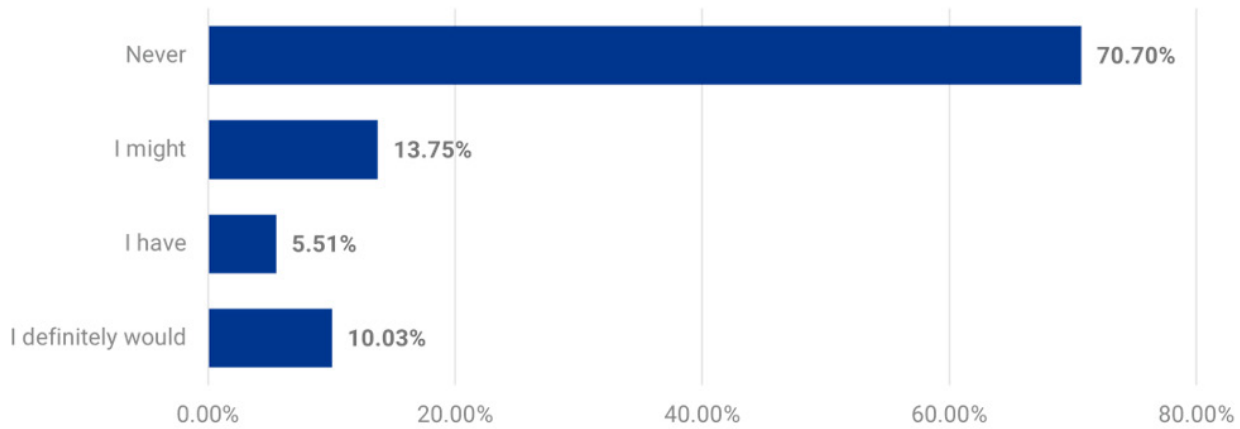
Would you consider any of the following:

Leaving out information or providing false information on an insurance application to get coverage or to get coverage at a lower rate

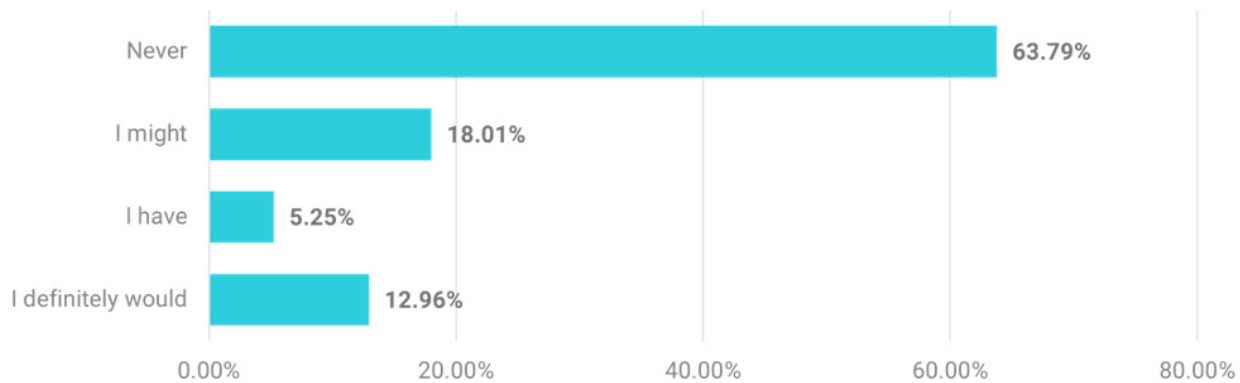


Question 5 - Cont'd
Would you consider any of the following:

Giving misleading information about an incident/accident to get insurance coverage for something the policy doesn't cover

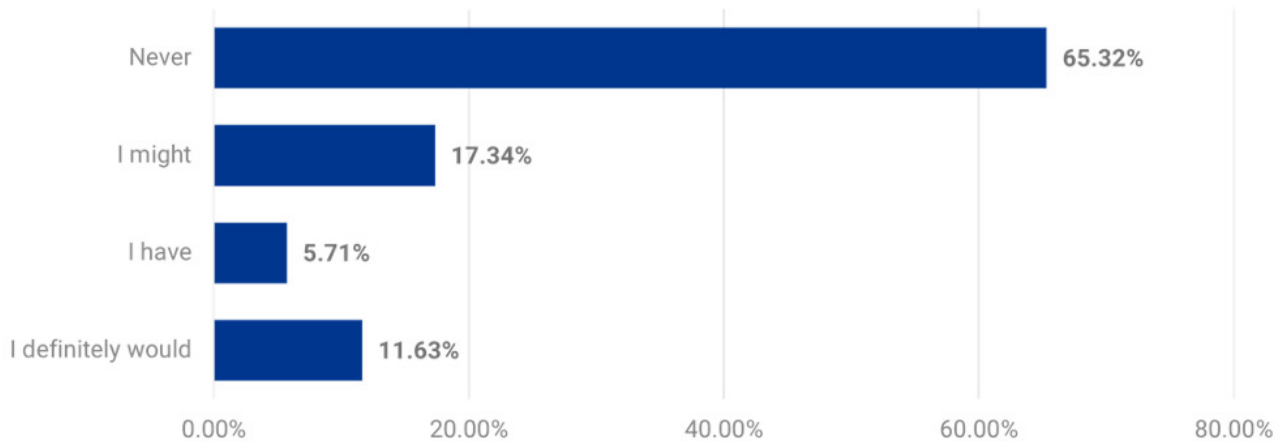


Including damages that had happened before a storm in a claim for damage to your home

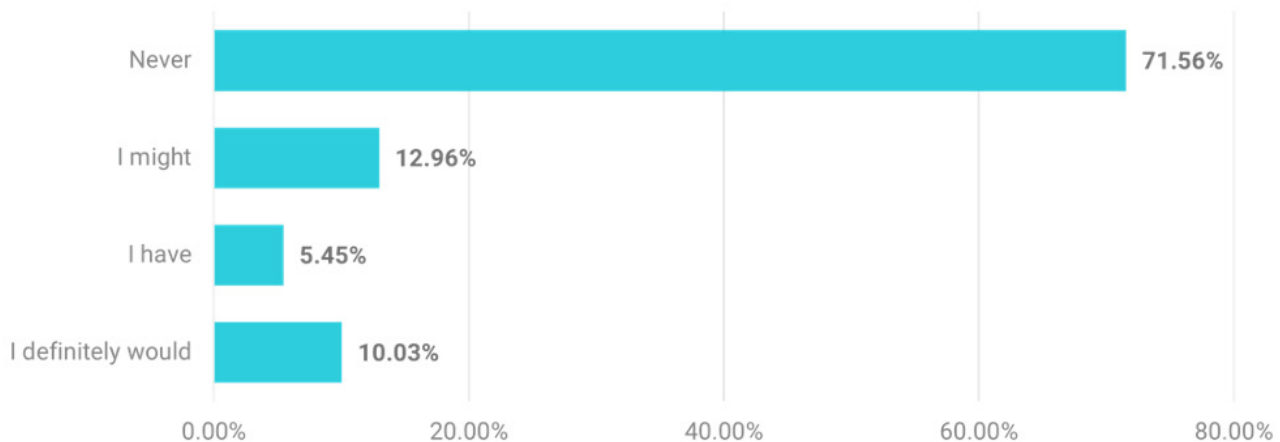


Question 5 - Cont'd
Would you consider any of the following:

Including damages that happened before the accident in a claim for vehicle damage caused in a car accident

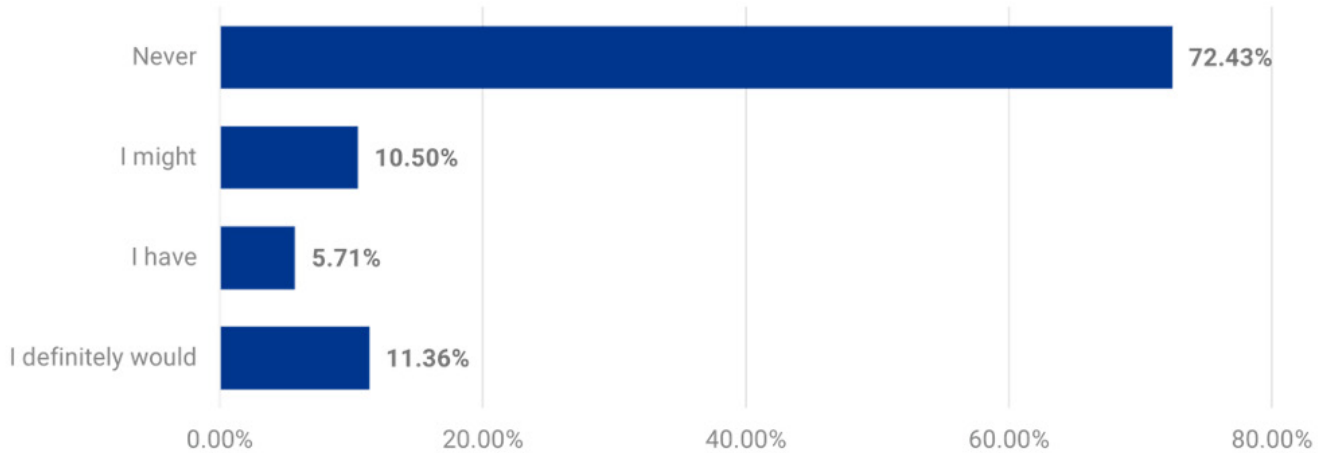


Giving an insurance company an address in an area with lower car insurance premiums although you don't live there

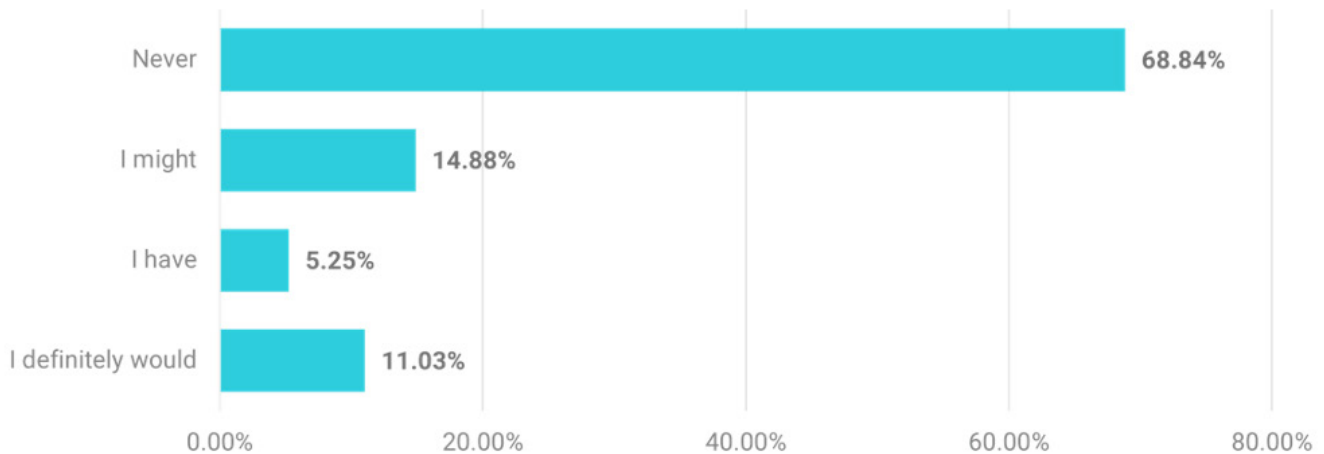


Question 5 - Cont'd
Would you consider any of the following:

Submitting a claim for an off-work recreation injury to an employer so it would be covered by workers compensation



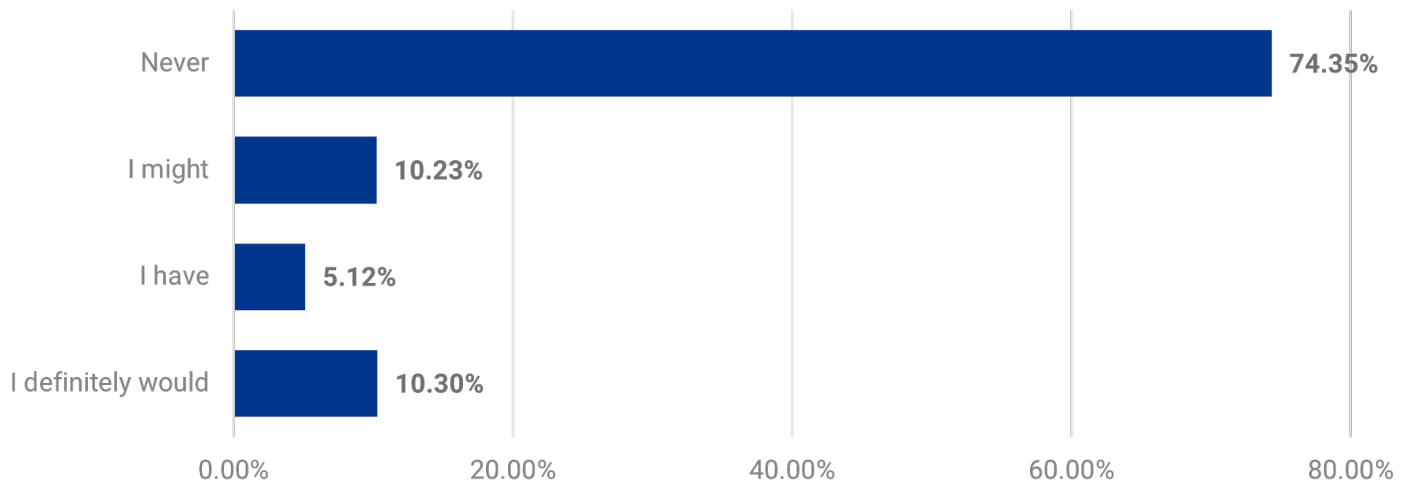
Adding a few extra or more expensive items when filing a claim for items that actually were stolen



Question 5 - Cont'd

Would you consider any of the following:

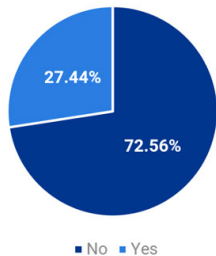
Helping a medical provider to bill an insurance company for treatment you didn't receive



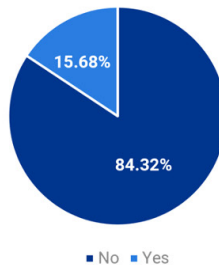
Question 6

Do you know anyone who has done any of following?

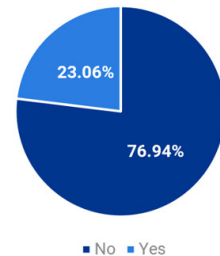
Leaving out information or providing false information on an insurance application to get coverage or to get coverage at a lower rate



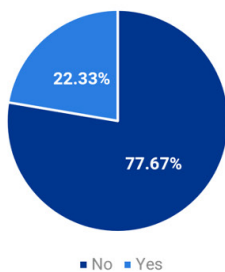
Buying insurance AFTER an accident has already happened and then filing a claim



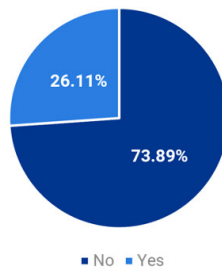
Giving misleading information about an incident/accident to get insurance coverage for something the policy doesn't cover



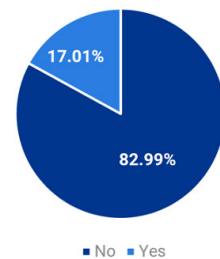
Including damages that had happened before a storm in a claim for damage to their home



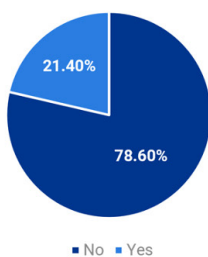
Including damages that happened before the accident in a claim for vehicle damage caused in a car accident



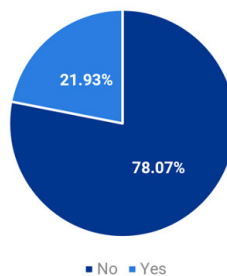
Giving an insurance company an address in an area with lower car insurance premiums although they don't live there



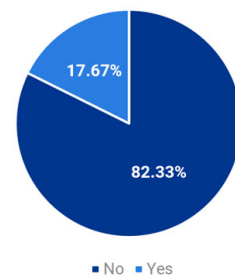
Submitting a claim for an off-work recreation injury to an employer so it would be covered by workers compensation



Adding a few extra or more expensive items when filing a claim for items that actually were stolen



Helping a medical provider to bill an insurance company for treatment they didn't receive



Question 7

In question 7, consumers provided information on who they thought committed the most insurance fraud.

Respondents believe policyholders and claimants who inflate or submit fraudulent claims commit the least amount of fraud.

Who do you believe commits most insurance fraud?

(Rank your responses from 1 being the lowest amount of fraud to 4 being the most amount of fraud)

Policyholders and claimants who inflate or submit fraudulent claims	1	595	39.53%
	2	362	24.05%
	3	276	18.34%
	4	272	18.07%
Insurance companies that don't pay legitimate claims	1	359	23.85%
	2	282	18.74%
	3	325	21.59%
	4	539	35.81%
Unscrupulous attorneys who file frivolous lawsuits	1	302	20.07%
	2	464	30.83%
	3	441	29.30%
	4	298	19.80%
Medical providers, body shops, and contractors who get people to submit fraudulent claims	1	249	16.54%
	2	397	26.38%
	3	463	30.76%
	4	396	26.31%

Question 8

In question 8, consumers identified who they thought would most likely commit insurance fraud.

Respondents believe people who don't understand that what they are doing is fraud are the most likely to commit insurance fraud. Interestingly, respondents believe people who commit fraud because they need money are the least likely to commit fraud.

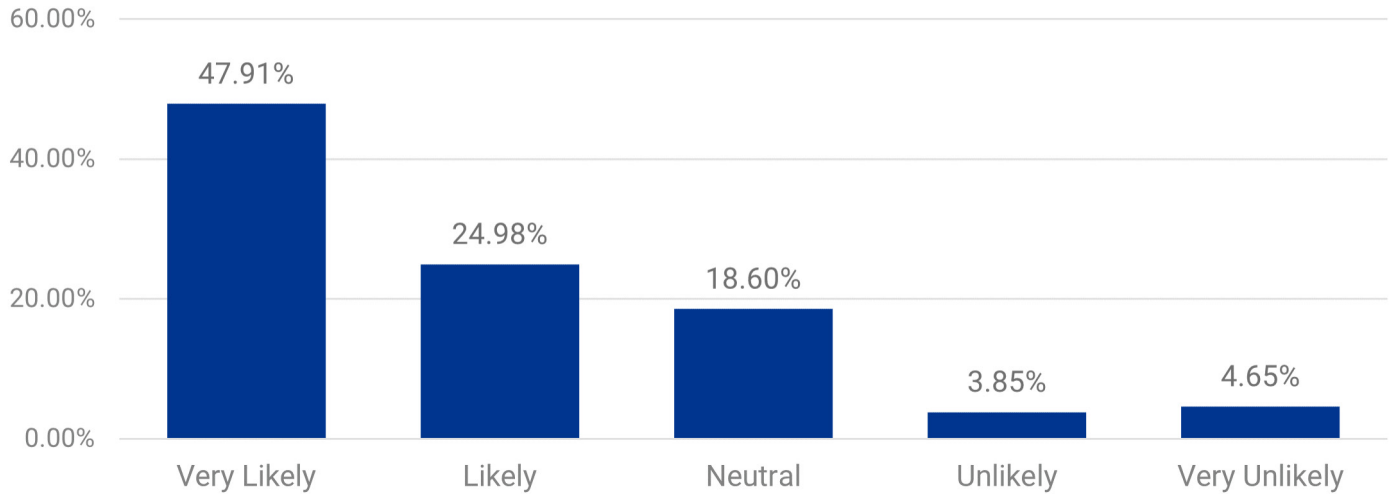
Which type of consumer do you think is most likely to commit Insurance fraud?

(Rank in order from 1 being the least likely to commit fraud to 4 being the most likely to commit fraud)

People who feel insurance companies have mistreated them and can't be trusted	1	407	27.04%
	2	452	30.03%
	3	358	23.79%
	4	288	19.14%
Honest people who are misled by contractors, attorneys, medical providers or others	1	335	22.26%
	2	345	22.92%
	3	433	28.77%
	4	392	26.05%
People who commit fraud because they need money	1	519	34.49%
	2	354	23.52%
	3	337	22.39%
	4	295	19.60%
People who don't understand that what they are doing is fraud	1	244	16.21%
	2	354	23.52%
	3	377	25.05%
	4	530	35.22%

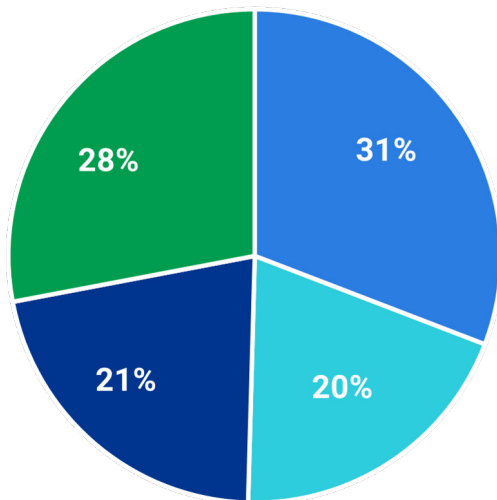
Question 9

If you attempted to commit insurance fraud, how likely do you think it is that you would be caught?



Question 10

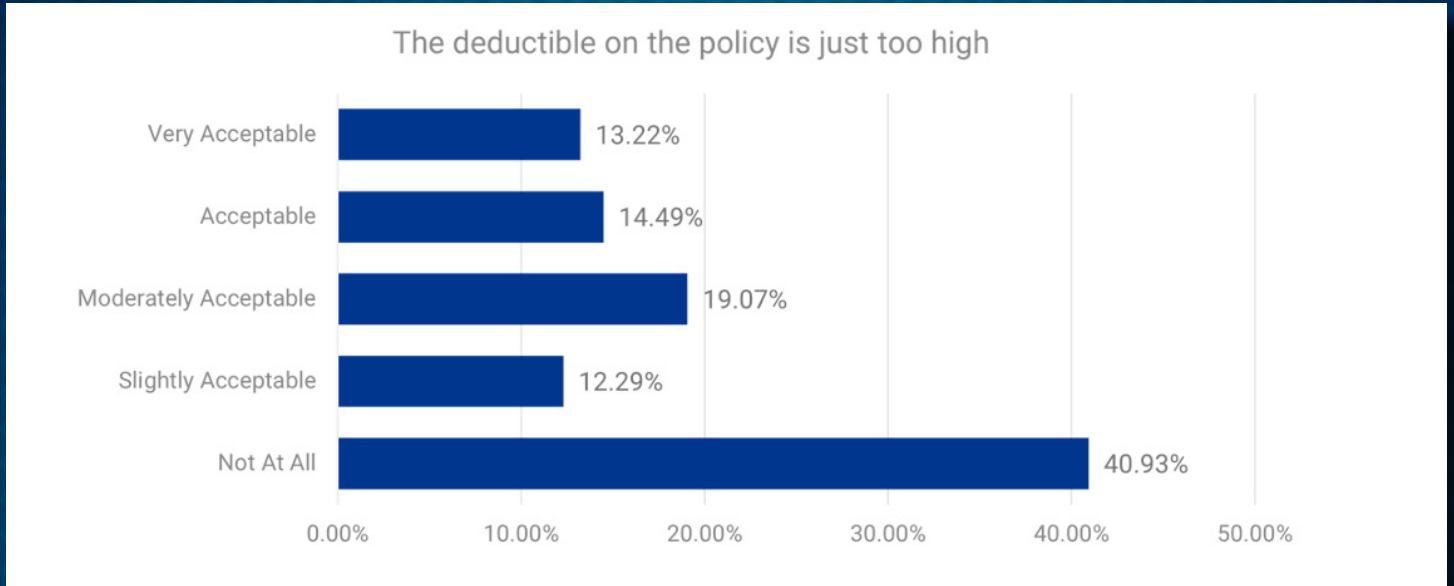
Which of these do you think is the most appropriate response when someone submits a fraudulent claim?



- ☒ Allow them to tell the truth; then the insurer pays the part of the claim they are owed
- ☒ The insurer denies the entire claim
- ☒ The insurer denies the entire claim and cancels the policy
- ☒ The insurer denies the entire claim and the person faces criminal charges

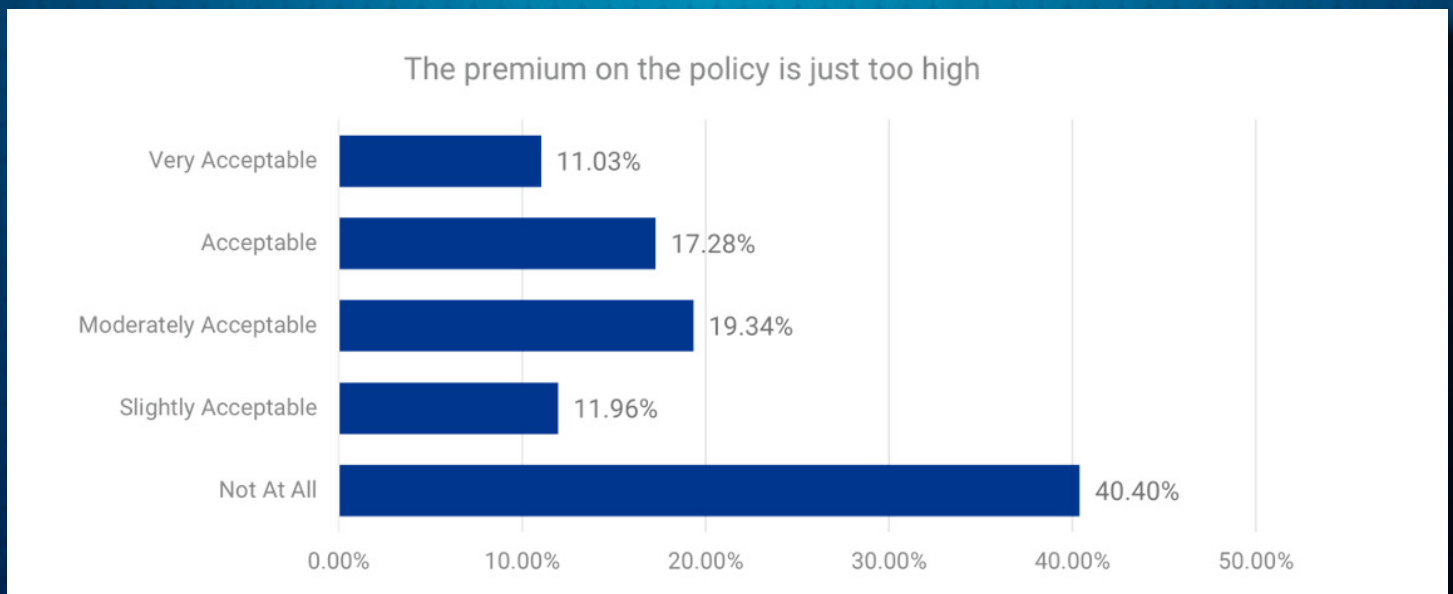
Question 11

How acceptable is each of these reasons to explain why someone would commit insurance fraud?



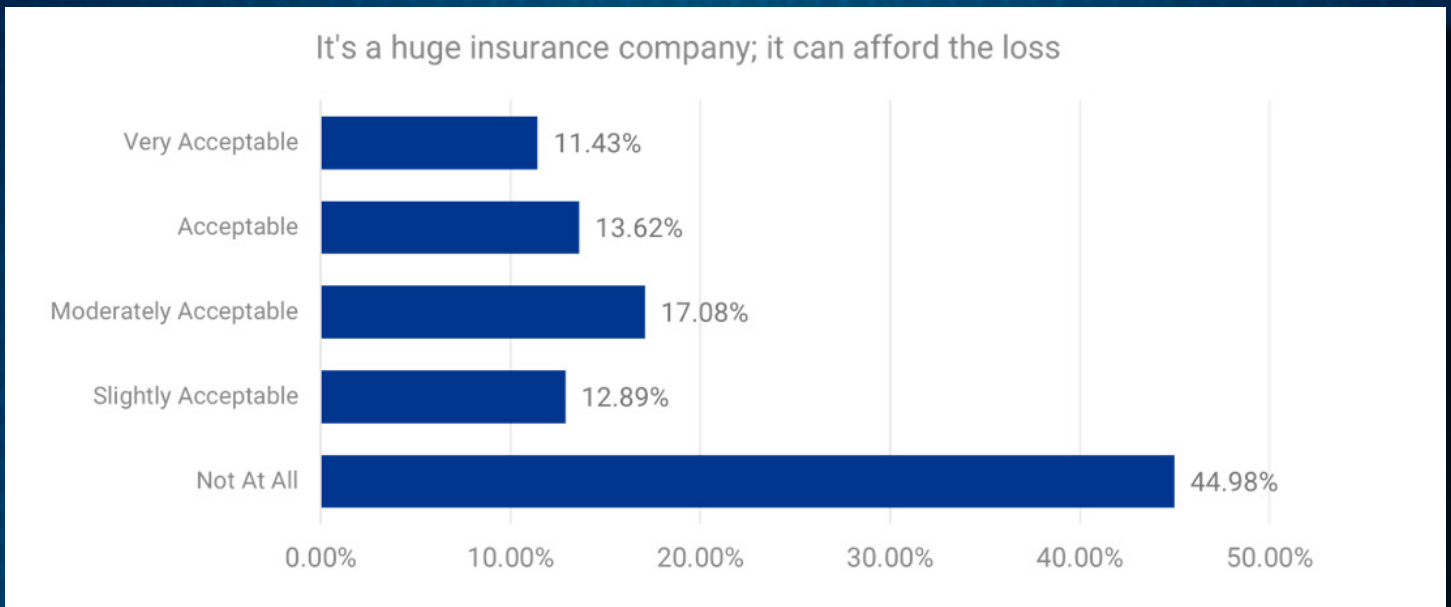
Question 11 - Cont'd

How acceptable is each of these reasons to explain why someone would commit insurance fraud?



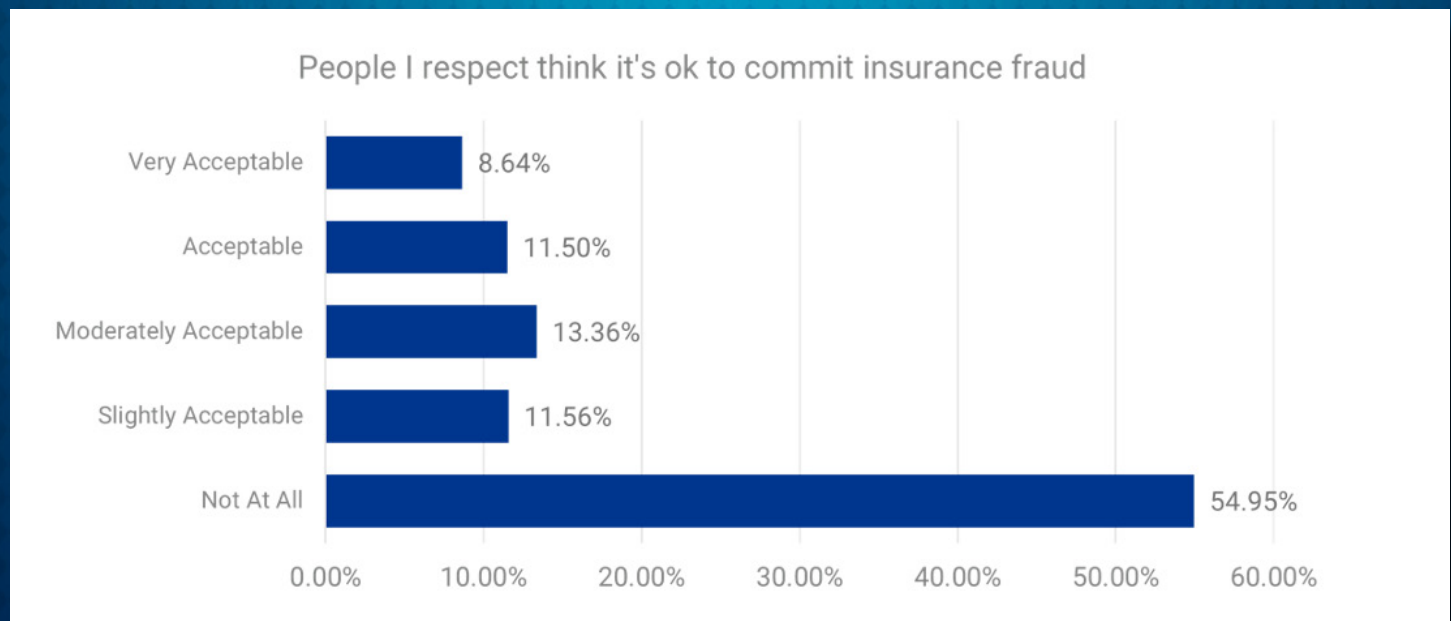
Question 11 - Cont'd

How acceptable is each of these reasons to explain why someone would commit insurance fraud?



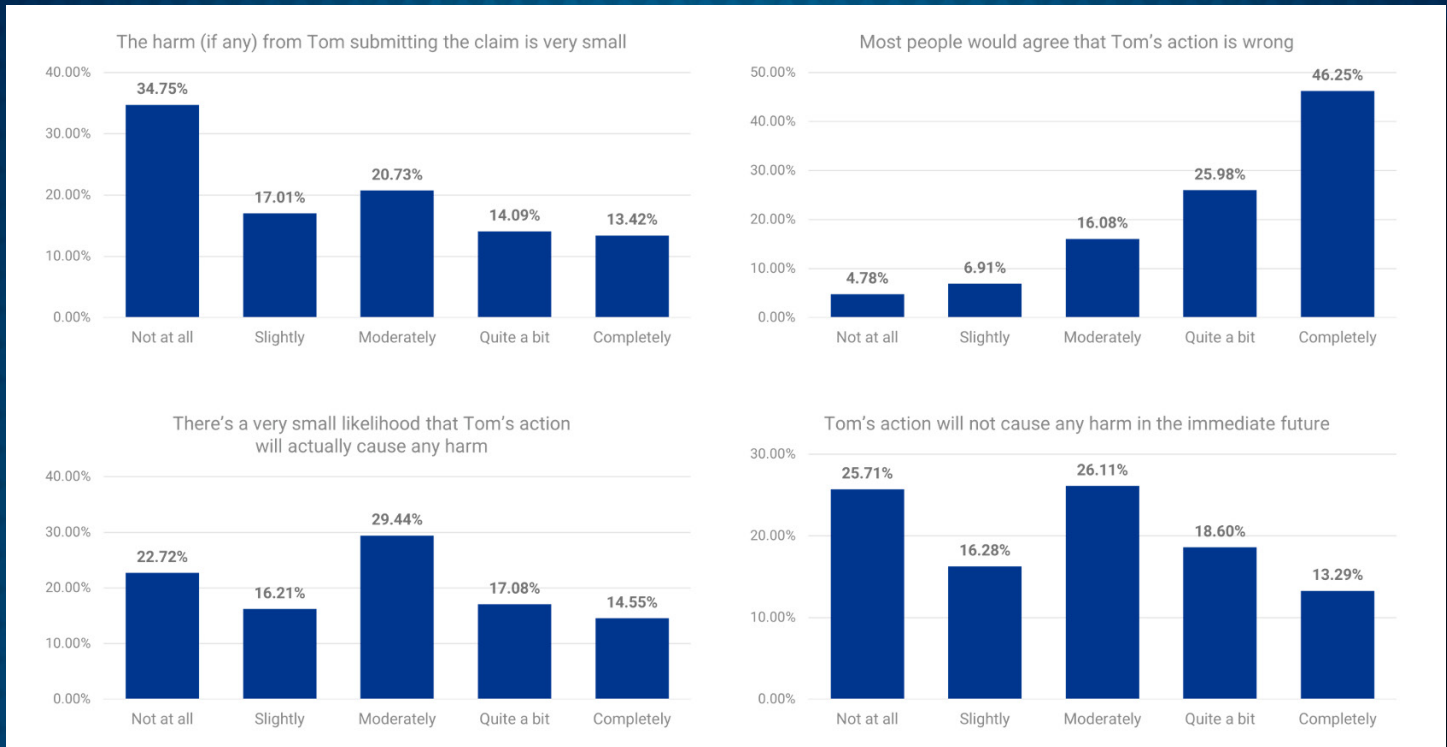
Question 11 - Cont'd

How acceptable is each of these reasons to explain why someone would commit insurance fraud?

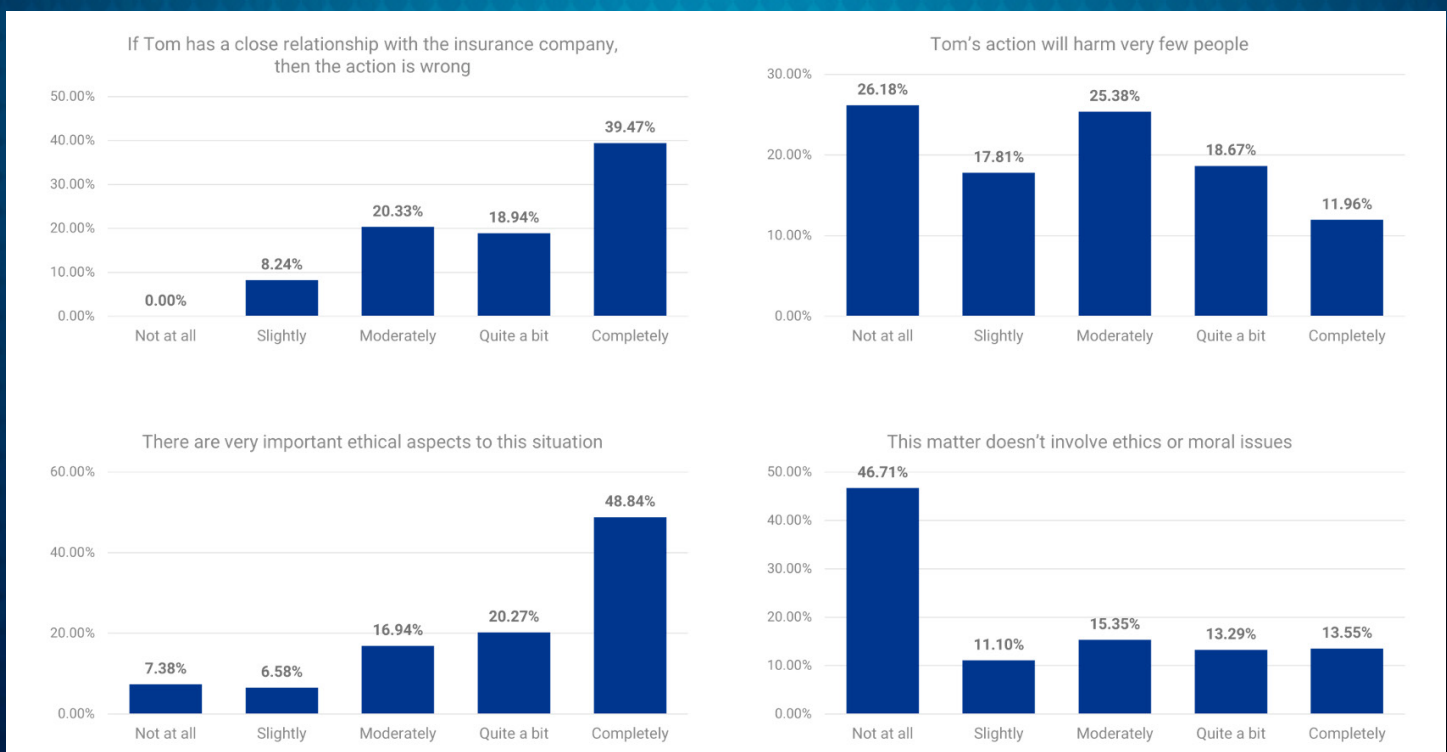


Question 12

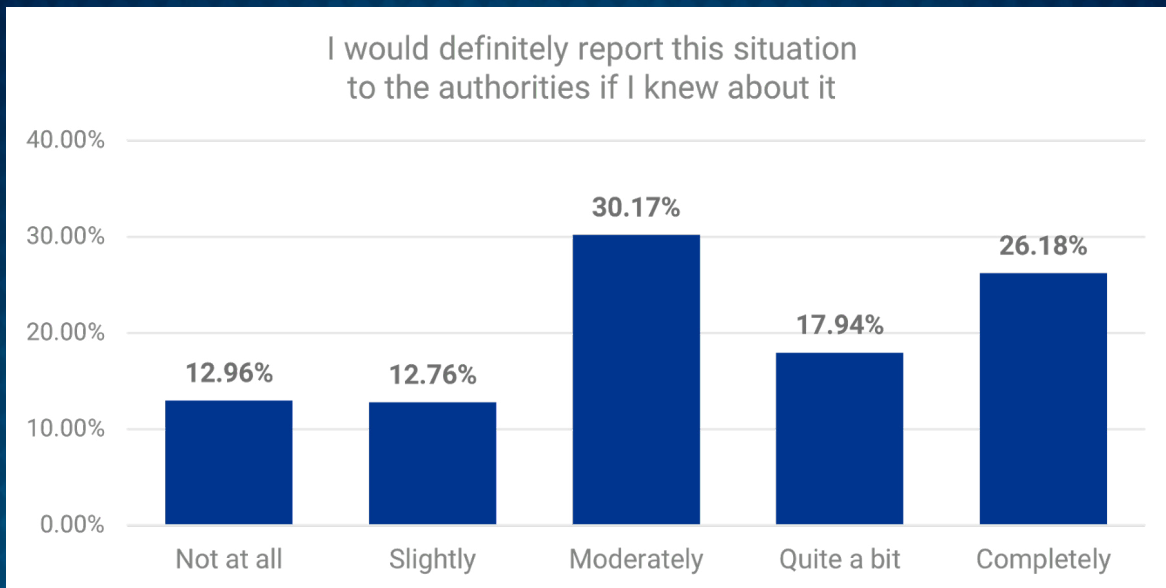
A storm blew shingles off Tom's house. A friend was visiting at the time and her car was parked in the driveway. The roof of the friend's car was already dented but she asks Tom to include a claim to repair her car roof in his claim for storm damage. Tom includes her car damage in the claim he submits. How much do you agree with each of the following?



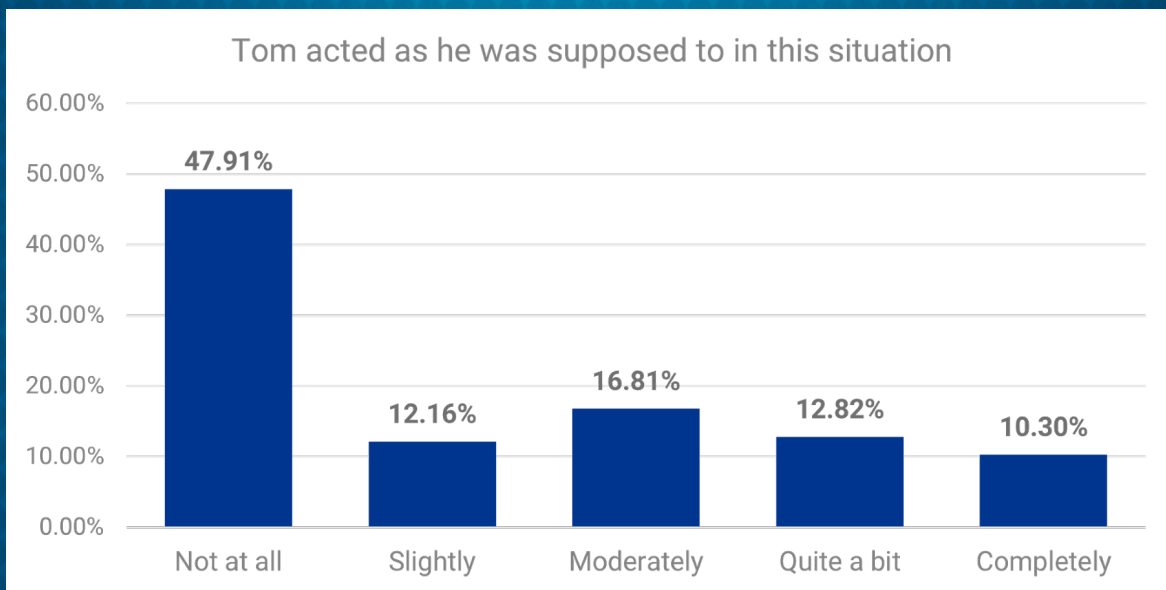
Question 12 - Cont'd



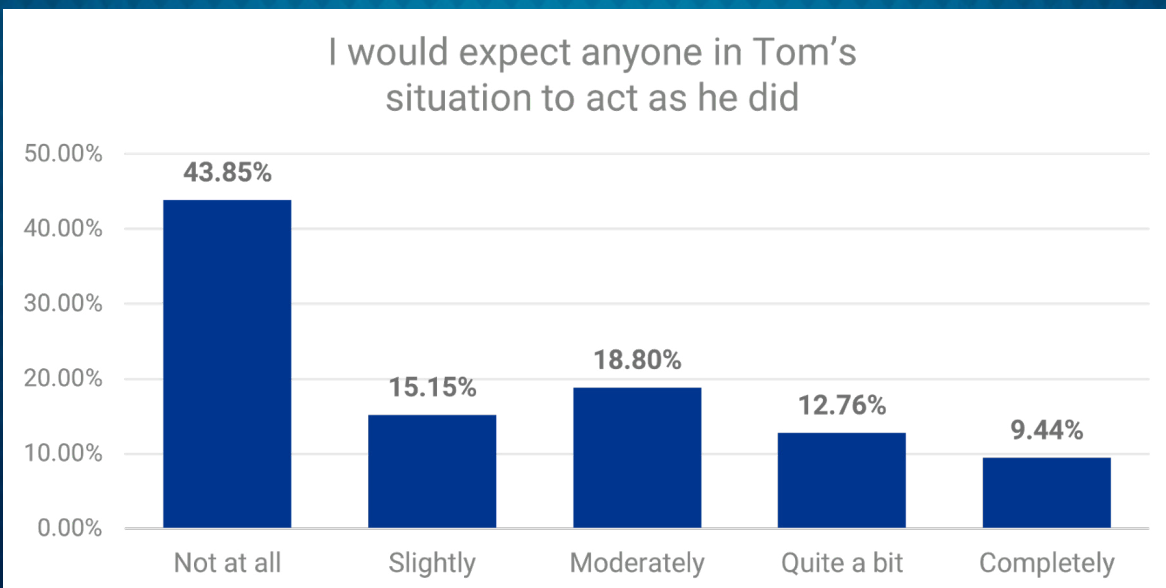
Question 12 - Cont'd



Question 12 - Cont'd

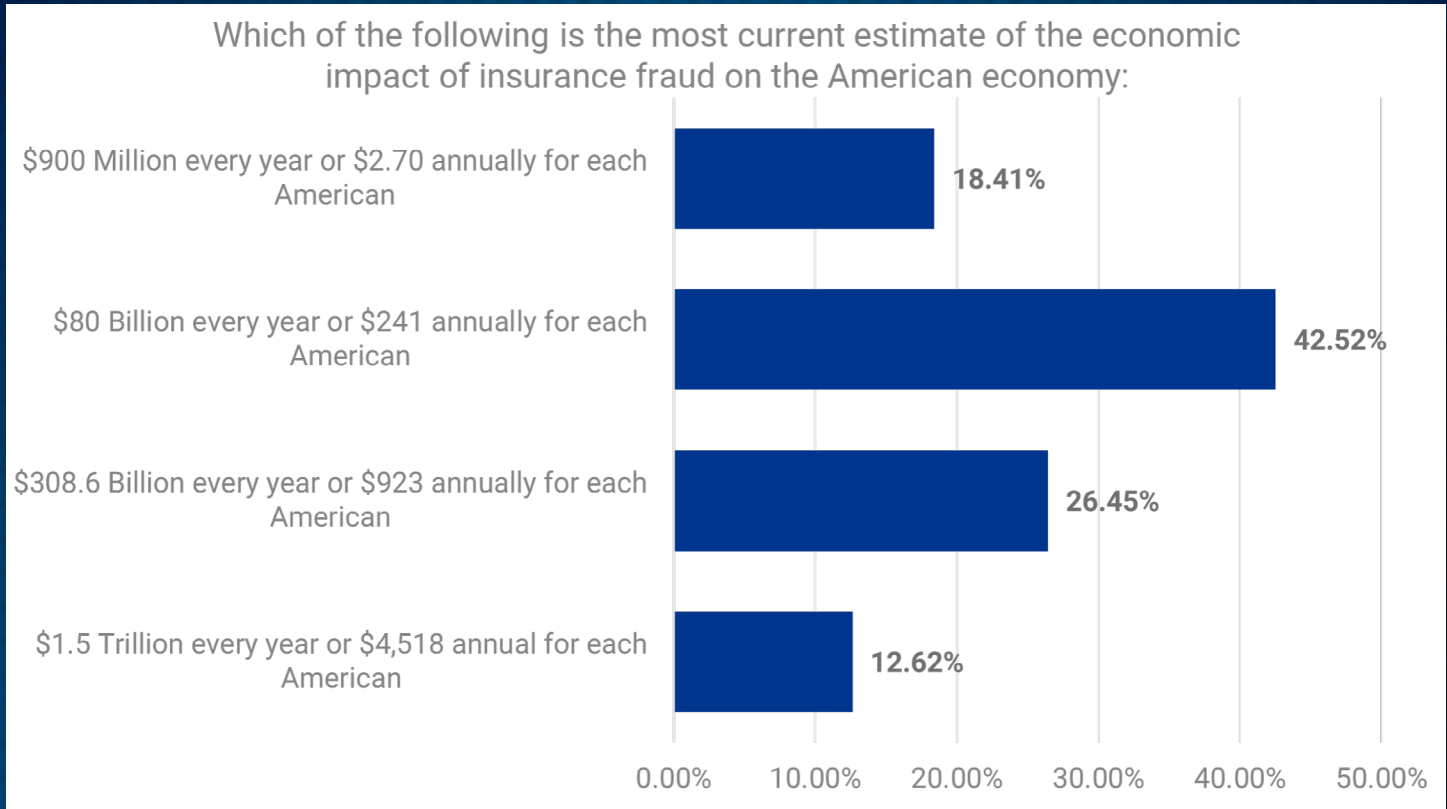


Question 12 - Cont'd



Question 13

In question 13, the majority of respondents underestimate the cost of insurance fraud on the American people.



Question 14

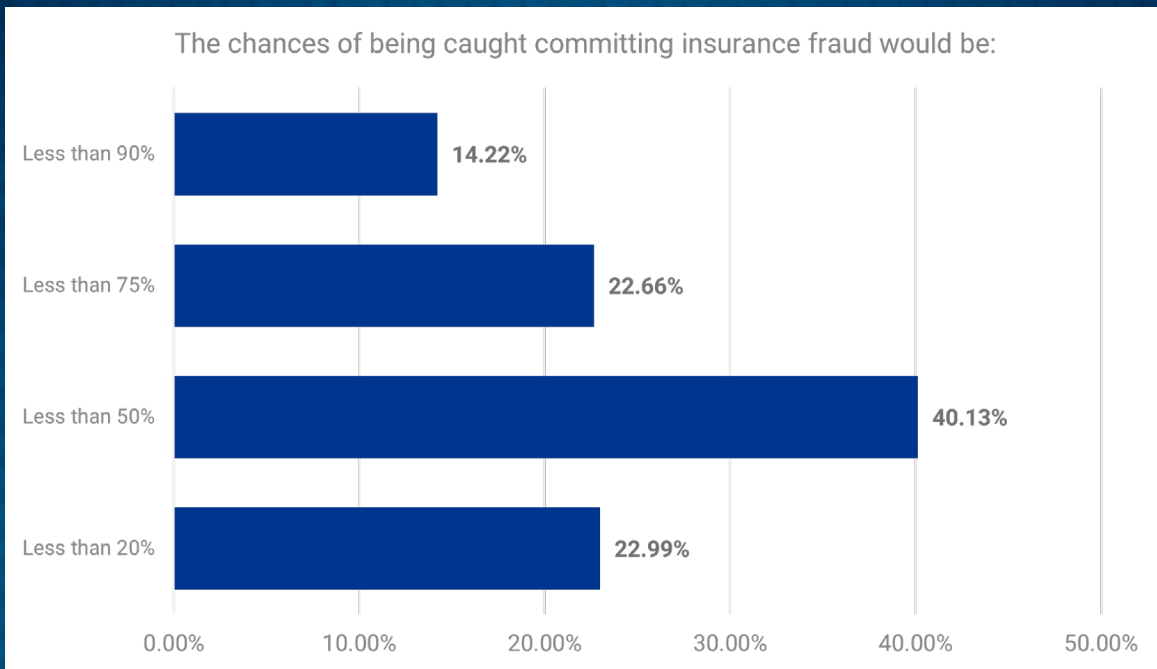
In question 14, consumers were asked if insurance companies are able to identify fraudulent claims. Respondents felt insurance companies really do not care about investigating insurance fraud, because they just pass the cost of the fraud on to consumers through higher premiums.

Please rank the following statements about whether insurance companies are able to identify fraudulent claims.

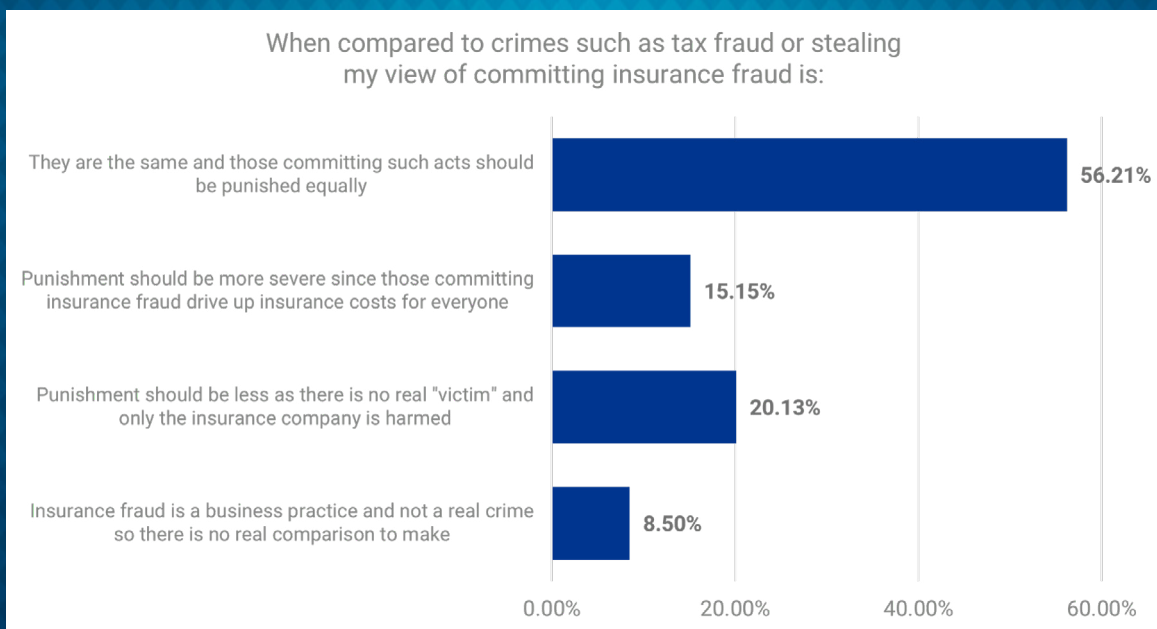
(Rank 1 as your lowest agreement and 4 as your highest agreement)

Insurance companies are skilled at identifying fraud and there is a high probability of being caught	1	526	34.95%
	2	298	19.80%
	3	315	20.93%
	4	366	24.32%
Insurance companies mainly focus on large claims, so committing fraud on smaller claims or to cover deductibles will probably never be identified or investigated	1	388	25.78%
	2	464	30.83%
	3	436	28.97%
	4	217	14.42%
There is so much insurance fraud that insurance companies at best only identify a very small amount of the fraud which is occurring	1	354	23.52%
	2	470	31.23%
	3	432	28.70%
	4	249	16.54%
Insurance companies really do not care about investigating insurance fraud because they just pass the cost of the fraud on to consumers through higher premiums	1	237	15.75%
	2	273	18.14%
	3	322	21.40%
	4	673	44.72%

Question 15

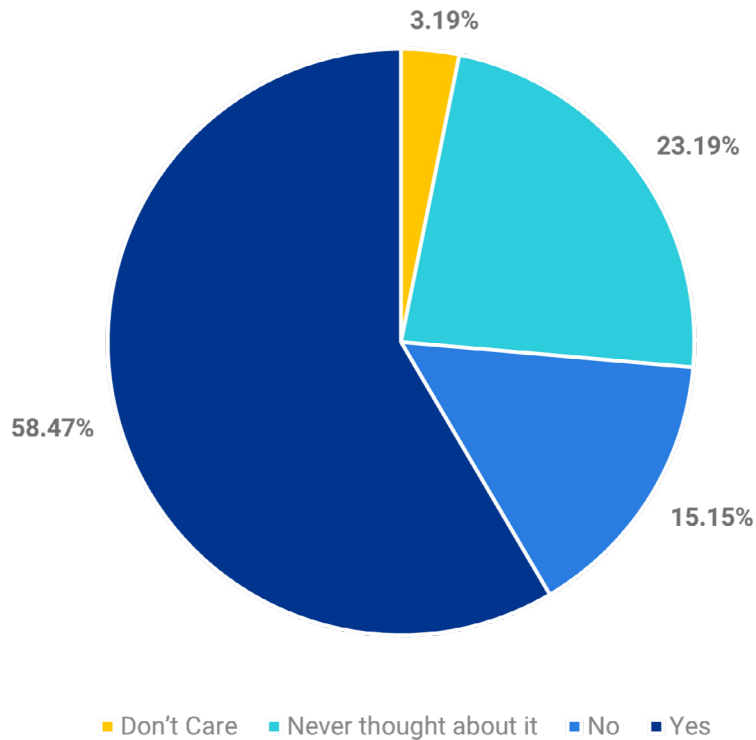


Question 16



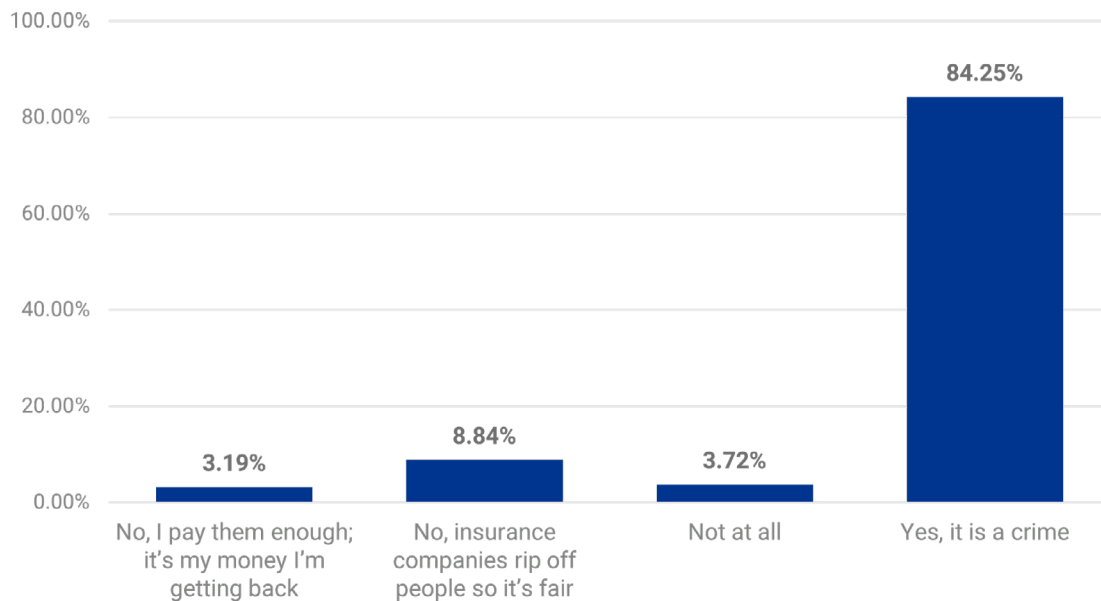
Question 17

Do you believe you are personally affected by insurance fraud committed by other people or groups across the U.S.?

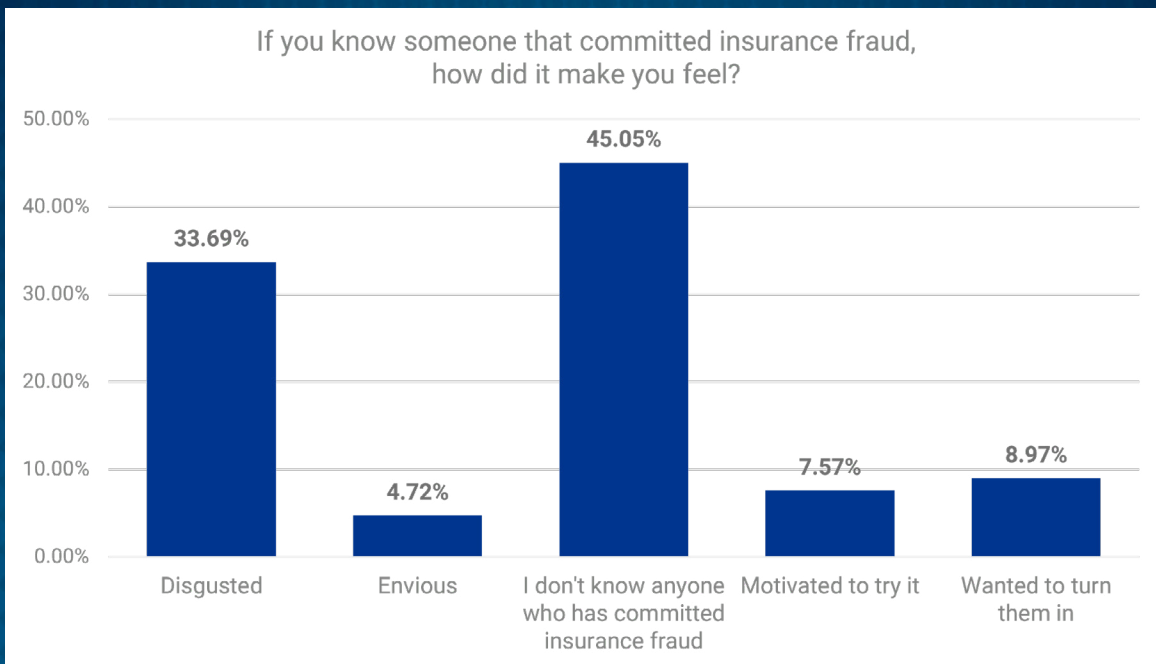


Question 18

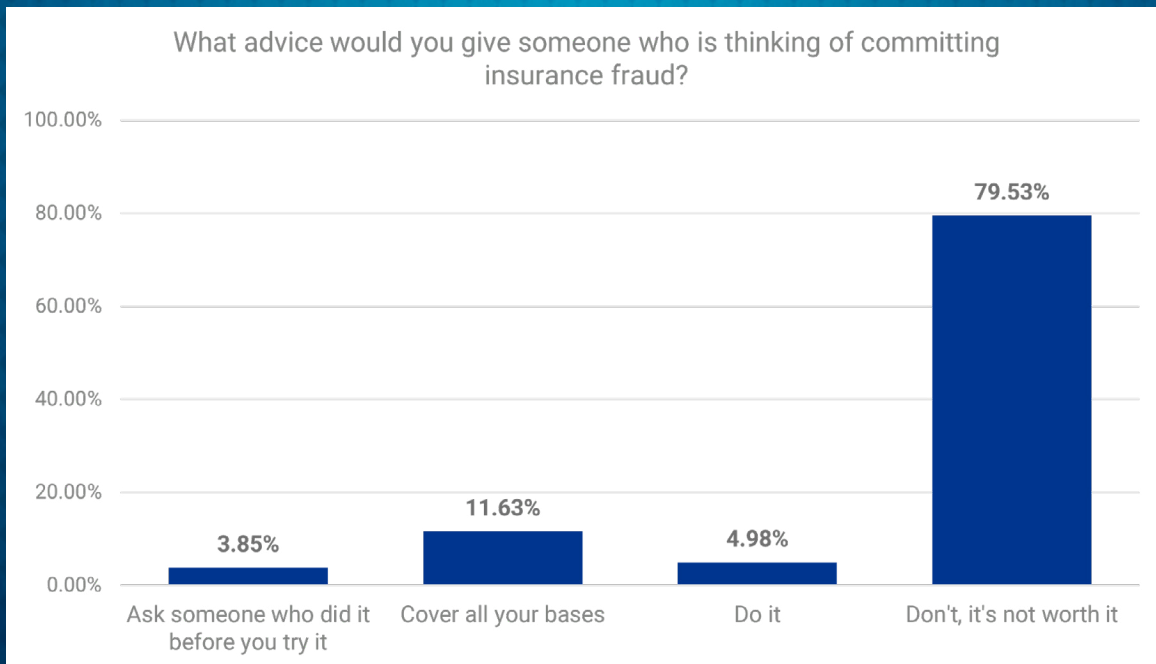
Do you consider insurance fraud to be a crime?



Question 19



Question 20



CONCLUSION

The analysis presented in this study provides valuable insights into the characteristics of individuals, particularly younger generations, and how they can be more tolerant of fraud and envious of those who commit fraud.

By examining various demographic categories, we have been able to identify the trends discussed in the study that shed light on the factors contributing to an increase in insurance fraud. The data from this survey will serve as a baseline for future studies that touch on how Americans view insurance fraud.

The Partnership



About the Coalition The Coalition Against Insurance Fraud is America's only antifraud alliance speaking for consumers, insurance companies, government agencies and others. Through its unique work, the Coalition empowers consumers to fight back, helps fraud fighters to better detect this crime and seeks to deter more people from committing insurance fraud.

The Coalition supports this mission with a large and continually expanding armory of practical tools—Information, research and data, services, and insight - as a leading voice in the antifraud community.

Formed in 1993, the Coalition is made up of nearly 300 member organizations, and they unite to fight all forms of insurance scams regardless of who commits the fraud.

Visit: Insurancefraud.org



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